Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

KEVIN BALDADO,

Petitioner,

V.

HAWAII MANAGEMENT ALLIANCE ASSOCIATION

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF HAWAI`I

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

1. Whether a state external review law that subjects a small number of coverage denials to an adversarial process as part of regulating health plans, but does not provide plan participants a legal right to an independent benefit determination implicates the enforcement scheme of Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1132 (a) sufficiently to warrant preemption with respect to participants in plans governed by 29 U.S.C.S. § 1103(a).

2. Whether the *Rush Prudential* test, providing that external review laws are saved so long as they do not "so resemble an adjudication as to fall within *Pilot Life*'s categorical bar. ." is the appropriate test to apply where the external review is part of a comprehensive regulatory plan administered by the state agency assigned to police health insurers' compliance with medical necessity and any other state-mandated benefits.

PARTIES TO THE PROCEEDINGS

Petitioner Kevin Baldado was the Appellee-Appellee in the appeal to the Supreme Court of Hawai`i. Petitioner Baldado participated in an ERISA plan and requested an external review of Respondent Hawaii Management Alliance Association's denial of coverage for a bone marrow transplant procedure prescribed by his treating physician.

Respondent Hawaii Management Alliance Association was the Appellant-Appellant.

In addition to the parties named in the caption, the Insurance Commissioner and the Division of Insurance, of the Department of Commerce and Consumer Affairs, State of Hawaii were also Appellees-Appellees in the appeal to the Hawaii State Supreme Court.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Kevin Baldado respectfully petitions for a writ of certiorari to review the judgment of the Supreme Court of Hawai`i in this case.

OPINIONS BELOW

The amended opinion of the Supreme Court of Hawai`i is reported at *Haw. Mgmt. Alliance Ass'n v. Ins. Comm'r*, 106 Hawai`i 21, 100 P.3d 952 (Haw. 2004). The opinion and Order of the First Circuit Court is unpublished.

The opinion and Order of the First Circuit Court are set forth in the Appendix, *infra*, at 1a-3a. The Judgment of the First Circuit Court is set forth in the Appendix, *infra*, at 4a. The opinion of the Hawai`i Supreme Court is set forth in the Appendix, *infra*, at 5a-33a and the Judgment on Appeal, filed December 28, 2004, is set forth in the Appendix, *infra*, at 34a-37a.

JURISDICTION

The amended opinion of the Supreme Court of Hawai`i was issued on December 16, 2004, and Notice of Final Judgment was entered on December 28, 2004, pursuant to Rule 36 of the Hawai`i Rules of Appellate Procedure. This Court has jurisdiction under 28 U.S.C.S. § 1257(a).

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The relevant provisions of the McCarran-Ferguson Act, 15 U.S.C.S. §§ 1011-12, are set forth in the Appendix, *infra*, at 38a. The relevant provisions of the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1001 *et seq.* ("ERISA"), are set forth in the Appendix, *infra*, at 38a-41a.

Section 4-10 of Illinois's Health Maintenance Organization Act, 215 Ill. Comp. Stat., ch. 125, § 4-10 (2004), is set forth in the Appendix, *infra*, at 41a-42a. The relevant provisions of the Hawaii Patient Bill of Rights and Responsibilities Act of 1998, Chapter 432E, Hawai`i Revised Statutes (HRS) (2004) are set forth in the Appendix, *infra*, at 42a-50a. The original Patient Bill of Rights and Responsibilities, 1998 Haw. Sess. L. Act 178, codified at Chapter 432E, HRS, is set forth in the Appendix, *infra*, at 50a-61a. The relevant portions of 1999 Haw. Sess. L. Act 137, adding sections 432E-1.5, 11, -12, and -13, and amending, *inter alia*, HRS 432E-5, -6, and 7, are set forth in the Appendix, *infra*, at 61a-66a. The relevant portions of 2000 Haw. Sess. L. Act 250, amending sections 432E-5 and -6, and adding the medical necessity definition at HRS § 432E-1.4, are set forth in the Appendix, *infra*, at 66a-79a. The relevant provisions of Hawai`i's Prepaid Health Care Act of 1974, Chapter 393, HRS, are set forth in the Appendix, *infra*, at 79a-84a. The relevant provisions of the Hawaii Insurance Code are set forth in the Appendix, *infra*, at 84a. The relevant provisions of the Hawaii Administrative Procedure Act, Chapter 91, HRS, are set forth in the Appendix, *infra*, at 84a-85a; with the related provision of Chapter 602, which is set forth in the Appendix, *infra*, at 85a.

The relevant portions of the Maryland Insurance Code, Appeals and Grievance Laws, are set forth in the Appendix, *infra*, at 86a-89a. For the Court's further convenience, portions of the Missouri Revised Statutes are provided in the Appendix, *infra*, at 89a-90a. Portions of the New Mexico Patient Protection Act are provided in the Appendix, *infra*, at 90a-91a; and portions of the New Mexico Administrative Code are provided in the Appendix, *infra*, at 91a-93a. Portions of the Delaware Statutes are provided in the Appendix, *infra*, at 93a-95a. Portions of the Michigan Patient's Right to Independent Review Act are provided in the Appendix, *infra*, at 95a-96a.

The Hawai`i Insurance Commissioner's Annual External Review Report, December 2004 is provided in the Appendix, *infra*, at 97a-98a.

STATEMENT

The "I know it when I see it" test[1] for external review laws that emerged from this Court's majority decision in *Rush Prudential HMO, Inc. v. Moran*[2]—that external review laws are saved so long as they do not "so resemble an adjudication as to fall within *Pilot Life*'s categorical bar. . ."—left the status of a number of state's laws in doubt due to the variety of existing approaches to external review, and this case is one of the first products of the resulting confusion. Every state in the nation is caught between the duty to protect consumers and regulate insurance, and the problem of straying too far into conflict with ERISA's enforcement scheme to survive federal preemption. At least one state's high court has previously determined that ERISA does not preempt a substantially similar comprehensive law aimed at correcting perceived problems within the insurance industry regarding benefit denials.[3] Many states have conceived processes that differ from the statute at issue in *Rush Prudential*, and most provide a right to judicial review. The Hawai`i Supreme Court's misinterpretation of *Rush Prudential* in this case can be expected to cause further confusion unless this Court makes it clear that ERISA does not interfere with the states' right to conduct adversarial inquiries into compliance with mandated benefits and medical necessity requirements simply because such inquiries resemble an adjudication, or because procedural due process concerns impose a right to judicial review of the determination from such proceedings.

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[1] *See Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

[2] 536 U.S. 355, 381, 122 S. Ct. 2151, 2168, 153 L. Ed. 2d 375, 400 (2002).

[3] See Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md., 371 Md. 455, 810 A.2d 425 (2002), discussed infra beginning at 20.

Hawai`i's external review law, HRS § 432E-6,[4] is part of a comprehensive regulatory scheme designed to provide Hawai`i's insurance commissioner with jurisdiction to regulate any gate-keeping activities managed care plans might employ to deprive consumers of benefits.[5] The external review provision has never afforded participants the **legal right** to obtain an authoritative independent benefit determination,[6] and thus it resembles an enforcement scheme even less than § 4-10.[7] *Rush Prudential*, 536 U.S. at 384. The primary purpose of Hawai`i's external review provision is to invite insureds to submit adverse coverage decisions for the commissioner to review, providing him with grist for his regulatory mill.

The commissioner has had—and has exercised—discretion to reject requests for external review that fail to meet his criteria, and petitioners have no right to appeal such rejections. When the Hawaii Supreme Court decided this case, it was a matter of public record that the commissioner had summarily denied 45% of applications for review and convened a hearing on only 22% during the period from July 1, 2000 through June 30, 2004, a fact that substantially undercuts the court's erroneous determination that HRS § 432E-6 affords ERISA participants the "right" to judicial review of an adverse benefit determination.[8] The court's error evidences the need for clarification of the *Rush Prudential* test's application.

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[4] App., *infra*, at 47a-50a.

[5] *See* Act 178, 1998 Haw. Sess. L., § 1, reproduced at App., *infra*, at 50a.

[6] Act 178 provides that, "an enrollee may appeal an adverse decision of a managed care plan to a three member review panel appointed by the commissioner" but also provides that only "upon a showing of good cause, the commissioner shall appoint the members of the panel. . ." App., *infra*, at 54a. Act 250, 2000 Haw. Sess. L., § 4, clarified the former phrase, "may appeal an adverse decision" by amending it to provide "may file a request for external review. . ." App., *infra*, at 68a.

[7] Section 4-10 of Illinois's Health Maintenance Organization Act, 215 Ill. Comp. Stat., ch. 125, § 4-10 (2000), App., *infra*, at 41a-42a.

[8] *See, i.e.*, Hawai`i Insurance Commissioner's Annual External Review Report, December 2004 is provided in the Appendix, *infra*, at 97a-98a.

A. Statutory Background

Well over 80% of Hawai`i's population has been covered in insured plans since the passage of the Prepaid Health Care Act of 1974 ("PHCA"),[9] mandating statewide, employer-based, comprehensive health insurance for employees not represented by collective bargaining. The enactment of the PHCA, under study since 1969, just preceded the enactment of ERISA. Congress added 29 U.S.C.S. § 1144 to federal law in 1983, exempting the PHCA from preemption by ERISA.[10] Thus, the policy grounds Justice Thomas referred to in his *Rush Prudential* dissent have significantly less force in this case:

> [E]xclusivity of remedies is necessary to further Congress' interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees: "To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits."

Rush Prudential, 536 U.S. 388 (Thomas, J., dissenting) (quoting *FMC Corp. v. Holliday*, 498 U.S. 52, 60, 112 L. Ed. 2d 356, 111 S. Ct. 403 (1990)).

Regulation of the PHCA was divided between the Hawai`i State Department of Labor and Industrial Rela-

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[9] Relevant portions are provided in the Appendix. *See* App., *infra*, at 79a-84a.

[10] (5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

29 U.S.C.S. § 1144 (b)(5) (2004), App., *infra*, at 41a.

tions and the Insurance Division of the Department of Commerce and Consumer Affairs, with the Division having responsibility for licensing and solvency. The health plan contractor industry that took root, due in part to the PHCA, became substantially concentrated in the late 1990s, and with it an increased possibility of large plans employing gate-keeping and improper constraints on utilization and access to finance price-predation against market entrants. The Hawai'i Legislature enacted the Patient Bill of Rights and Responsibilities, 1998 Haw. Sess. L. Act 178 to deal with the concerns over the potential for gate-keeping and other abuses. [11]

Act 178 clarified coverage mandates and resolved jurisdictional uncertainties by increasing the Insurance Division's role in regulatory oversight into policing compliance with mandated benefits. The Act was applicable to all forms of health insurance and health plans, including HMOs.[12] It required plans to establish an internal appeals process for all appeals and complaints. App., *infra*, at 53a-54a. Plans were also required to demonstrate to the insurance commissioner the availability and accessi-

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[11] App., *infra*, at 50a-61a. The preamble, § 1, discusses gatekeeping concerns. *Id.* at 50a.

[12] "Managed care plan" means any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

> (1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and
>
> (2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;

provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

Act 178, 1998 Haw. Sess. L., § 1, App., *infra*, at 51a-52a.

bility of required benefits for all enrollees "in the defined service area with reasonable promptness and in a manner which promotes continuity in the provision of health care services." App., *infra*, at 53a. The Act expressly prohibited any interference by a managed care plan with the information it required to be provided concerning all treatment options. *Id.*

The Legislature failed to achieve its ambition of resolving the definition of medical necessity in 1998. Section 5 of Act 178 therefore created a task force to report through the insurance commissioner on advice for amendments to the Act, chief among which was a medical necessity definition. The principal health plan contractors providing coverage to employers under the PHCA were designated members of the task force, as were some consumer advocates and government officials.[13]

Act 178 also created a mechanism for reviewing complaints of benefit denials to provide the commissioner with a means of determining whether a managed care plan was engaging in improper gate-keeping and other abuses. This original version of section 432E-6, entitled "Appeals to the commissioner," was short and spare in comparison to the present amended version. It provided that enrollees "may appeal an adverse decision of a managed care plan to a three-member review panel appointed by the commissioner." Act 178 § 6(a).[14] Before admitting an appeal to the process, the commissioner was to determine its merit: "Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint

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[13] Act 178 called for at least one representative from the department of health, disability compensation division of the department of labor and industrial relations, a health insurance company that provides accident and sickness policies, a mutual benefit society that provides health insurance, a health maintenance organization, the American Association of Retired Persons, the Hawaii Coalition for Health, the Hawai'i Business Health Coalition, the Legal Aid Society of Hawaii, the Hawaii Medical Association, an organization that represents nurses, and a hospital or an organization that represents hospitals. Act 178, 1998 Haw. Sess. L., § 5. App., *infra*, at 59a-60a.

[14] App., *infra*, at 54a.

the members of the panel and shall conduct a review hearing pursuant to [the Hawaii Administrative Procedure Act ("HAPA")]." *Id.* The HAPA requirement was mandated by minimum procedural due process under Hawai`i's constitution and related case law.[15]

The Patient Bill of Rights and Responsibilities task force provided amendments in 1999, recommending the addition of 3 sections to chapter 432E, along with other changes. Act 137, 1999 Haw. Sess. L., §1.[16] By unanimous vote, the task force recommended, among other changes, that the commissioner be given discretion to make "an award of a reasonable sum for attorney's fees and reasonable costs of suit in an action brought against the managed care plan. . . ." The authority was incorporated into section 432E-6 by Act 137. App., *infra*, at 66a. Section 432E-6 retained its title, "Appeals to the commissioner," but the process was further defined according to the task force's unanimous recommendations. The amended section 6 granted the Commissioner discretion to retain an independent medical expert trained in the field of medicine most appropriately related to the adverse determination being appealed. App., *infra*, at 65a. It also granted the commissioner greater discretion to reject appeals, expressly providing that he might dismiss frivolous or meritless appeals, *id.*; and did away with the three-member panel for controversies involving less than $500. *Id.* Finally, Act 137 also amended Chapter 432E to require the commissioner to report annually "the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed." Act 137, 1999 Haw. Sess. L., § 2, App., *infra*, at 62a.

The task force required another year to reach unanimous agreement on a medical necessity definition. In February 2000, it sent the Legislature a medical necessity definition it unanimously recommended adding to

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[15] *See, i.e., Brown v. Thompson*, 92 Haw. 1, 10, 979 P.2d 586 (1999).

[16] App., *infra*, at 62a.

Chapter 432E. 2000 Haw. Sess. L. Act 250 included the medical necessity definition added as HRS § 432E-1.4. App., infra, at 74a-79a. The implementing requirement was added to HRS § 432E-5 as new subparagraph "(d)." App., *infra*, at 67a. Act 250 further amended the external review section, HRS § 432E-6. Section 432E-6(a) was amended to clarify that enrollees "may file a request for external review of a managed care plan's final internal determination" revising the original language, "may appeal an adverse decision of a managed care plan. . ." which might be construed as a limitation on the commissioner's discretion. App., *infra*, at 68a. A revised subsection (a)(2) also provided the commissioner discretion to retain an independent review organization for the review as an additional alternative. *Id.* at 69a. The language of the provision granting the commissioner discretion to award attorneys' fees and costs was changed to reflect discretion to award fees and costs "incurred in connection with the external review." *Id.* at 72a. The section title, "Appeals to the commissioner" was also changed to "External review procedure." *Id.* at 68a.

With the addition of the medical necessity definition and the clarifications and additions to the external review provision, work on the Act was completed and the commissioner adjourned the task force. With the exception of a small number of minor technical corrections in 2003 and 2004, the Act remains the same today as it was after the Governor signed Act 250 into law. It was this HRS § 432E-6, as amended by Act 250, that the Hawai`i Supreme Court held is preempted by ERISA.

B. Factual Background of This Case

Kevin Baldado was diagnosed with metastatic renal carcinoma in September 2000. App., *infra*, at 6a. His physician requested authorization from HMAA to treat Baldado's cancer with a nonmyeloablative stem cell transplant. *Id.* HMAA denied the request stating that stem cell transplants were not covered for solid tumors. HMAA based the denial on "National guidelines." *Id.*

Mr. Baldado exercised the HMAA internal appeal rights mandated by HRS § 432E-5.[17] *Id.* HMAA's internal appeal process advised Mr. Baldado on January 23, 2001 that his request was denied, as his plan did not cover "investigational/experimental procedures," federal government health plans did not cover the transplant, and the transplant was not medically necessary. App., *infra*, at 6a-7a. A subsequent HMAA letter informed Mr. Baldado that its medical director had recommended the denial, which also exhausted all of HMAA's internal complaint and appeal procedures. *Id.* HMAA also advised Mr. Baldado, as required by HRS § 432E-5(d)[18] that he could file a request with the insurance commissioner for an external review of its final determination. App., *infra*, at 7a.

Mr. Baldado filed a request for an expedited (72-hour) external review of HMAA's denial under HRS § 432E-6.5,[19] on February 15, 2001. App., *infra*, at 7a. The same day, the commissioner informed HMAA of Mr. Baldado's request for an expedited external review and gave HMAA 48 hours to provide him with the documents HMAA used to make its final internal determination, any documents Mr. Baldado had submitted, and a list of all of Mr. Baldado's health care providers. *Id.* HMAA produced the documents and information and filed a legal memorandum in response to Mr. Baldado's appeal the next day. *Id.* The Commissioner issued a decision and order on February 20, 2001 concluding that Mr. Baldado failed to prove that HMAA's denial was improper, and upholding

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[17] App., *infra*, at 46a.

[18] d) A managed care plan shall send notice of its final internal determination within sixty days of the submission of the complaint to the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the commissioner. The notice shall include the following information regarding the enrollee's rights and procedures:

(1) The enrollee's right to request an external review;

(2) The sixty-day deadline for requesting the external review;

(3) Instructions on how to request an external review; and

(4) Where to submit the request for an external review.

HRS § 432E-5, App., *infra*, at 46a.

[19] App., *infra*, at 30a.

HMAA's internal determination. *Id.* The Commissioner's coverage order also responded to HMAA's jurisdictional objection holding that, "A managed care plan's final internal determination is subject to external review, pursuant to HRS chapter 432E. As such, the review panel has jurisdiction over the subject external appeal." App., *infra*, at 7a-8a. Because the hearing was held pursuant to HAPA, HMAA had the right to appeal the commissioner's order, as did Mr. Baldado.[20] Neither appealed. Mr. Baldado was able to obtain the transplant through alternative means and his cancer is in remission at this time.

Mr. Baldado requested an award of his attorneys' fees and costs and, on March 1, 2001, the commissioner awarded Mr. Baldado the attorneys' fees and costs he requested, and directed HMAA to pay Mr. Baldado's attorney directly. App., *infra*, at 8a. HMAA filed a motion for reconsideration, which the commissioner denied.

C. Proceedings Below

HMAA exercised its right to appeal the commissioner's order granting attorneys' fees and costs to the circuit court. *Id.* HAPA provides for a review of agency decisions in contested cases to determine whether the agency's findings, conclusions, decisions, or orders are

> (1) In violation of constitutional or statutory provisions; or
>
> (2) In excess of the statutory authority or jurisdiction of the agency; or
>
> (3) Made upon unlawful procedure; or
>
> (4) Affected by other error of law; or
>
> (5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
>
> (6) Arbitrary, or capricious, or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

HRS § 91-14(g), App., *infra*, at 85a.

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[20] HRS § 91-14(a), App., *infra*, at 84a.

The circuit court upheld the commissioner's order granting Mr. Baldado's attorneys' fees and costs. App., *infra*, at 8a. HMAA exercised its further right of appeal from the circuit court's judgment on February 12, 2002. App., *infra*, at 9a. Appeals from the circuit court's review of an agency decision are directed to the Hawai`i Supreme Court under HRS § 91-15, App., *infra*, at 85a-86a. In its appeal, HMAA contested the commissioner's jurisdiction to consider the coverage denial on the grounds that Mr. Baldado's plan was an ERISA plan. App., *infra*, at 6a. In an opinion that omits discussion of material text in HRS § 432E-6 and fails to mention the provision's legislative history, the Hawai`i Supreme Court reviewed the commissioner's jurisdiction on both the coverage denial and the order to pay attorneys' fees and costs, and found implied conflict preemption in both instances. App., *infra*, at 5a-33a

The court held that it had the limited jurisdiction to determine whether the commissioner had jurisdiction to issue his order upholding the coverage denial, in addition to the order granting attorneys' fees and costs and the circuit court's order and judgment on that order from which HMAA had appealed. App., *infra*, at 11a.

The court held that HRS § 432E-6 is saved from express preemption because it meets the two-part test in *Kentucky Ass'n of Health Plans, Inc. v. Miller*.[21] App., *infra*, at 12a. The court held that HRS § 432E-6 "regulates insurance because the right to engage in business in Hawai`i is conditioned upon the insurer's submission to the external review procedure." *Id.* The court held that the second prong of the *Miller* test is also satisfied because HRS § 432E-6 "alters the terms of insurance policies by creating an additional review process for an insurer's denial of coverage." *Id.*

The court correctly determined that:

> [B]oth Rush Prudential and Aetna Health hold that a state may not create a new "cause of ac-

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[21] 538 U.S. 329, 155 L. Ed. 2d 468, 123 S. Ct. 1471 (2003).

> tion." Both cases preserve the states' right to regulate insurance so long as those insurance regulations do not conflict with ERISA's civil enforcement scheme. In sum, Aetna Health does not overrule Rush Prudential. Therefore, we hold that a state law that "regulates insurance" is not preempted so long as it does not create a new claim for relief and does not enlarge a claim for benefits beyond that available in § 1132(a).

App., *infra*, at 24a.

The court nonetheless determined that, HRS § 432E-6 "a law that 'regulates insurance,' conflicts with § 1132(a) because HRS § 432E-6 'so resembles an adjudication as to fall within Pilot Life's categorical bar.' Rush Prudential, 536 U.S. at 381." App., *infra*, at 24a.

REASONS FOR GRANTING THE WRIT

The Hawai`i Supreme Court's holding in this case creates fresh doubts regarding the borders of ERISA's saving clause and the application of the *Rush Prudential* test. It indicates that the majority opinion in *Rush Prudential* may have inadvertently "misdirected attention, [and] failed to provide clear guidance to lower . . .courts." *Miller*, 538 U.S. at 339. The Hawai`i court's decision also conflicts with at least one other state court's opinion rejecting the insurers' argument for ERISA preemption in a case involving a similar regulatory scheme providing a right to judicial review of the external review decision. Unless the Hawai`i court's error is corrected and the conflict resolved, confusion will plague the distinction between the states' powers to regulate insurance, which Congress intended to protect with ERISA's saving clause, and the narrow exception to conflict preemption that *Rush Prudential* afforded for those states that grant consumers the legal right to an independent non-judicial review of an adverse coverage decision, and particularly for the states that have implemented active enforcement plans that include external review as an integral part of policing compliance. The confusion promises to stymie

states' efforts to bring their regulatory design within ERISA's requirements.

I. The Hawai`i Court's Holding Expands the Scope of *Pilot Life* Into Territory Congress Intended to Save From Preemption

This Court rejected proposals to expand the *Pilot Life*[22] limits on insurance regulation in *Rush Prudential*, accepting as sufficiently regulatory a procedure providing Illinois insureds a legal right to obtain a second opinion concerning medical necessity. *Rush Prudential*, 536 U.S. at 383-84. The fact that the second opinion might settle the benefit claim's fate was deemed not to be a problem because § 4-10 "does not enlarge the claim beyond the benefits available in any action brought under § 1132(a)." *Id.* at 379-80. It is hard to imagine a case in which § 4-10 would not settle the fate of the claim as to the HMO because it is expressly bound by the result under the law.

Nothing in § 4-10's two paragraphs[23] discloses an active regulatory scheme concerned with ensuring that HMOs provide medically necessary care, but this Court assumed that to be the purpose of a law providing all plan participants with an extra layer of review that settles the fate of a claim. A number of states provide participants with similar legal rights to an independent review of a benefit denial as part of a passive enforcement approach similar to the Illinois plan. The *Rush Prudential* test is apt for use in testing whether each of those laws in their turn appears to too closely resemble an adjudication. *Id.* at 381.

Some states, Hawai`i included, have enacted external review laws that are administered by the state agency with oversight of the insurance industry. Those laws therefore differ substantially from the passive approach this Court reviewed in *Rush Prudential*. Among these active enforcement states, Hawai`i's external review law

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[22] *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549 (1987).
[23] App., *infra*, at 41a-42a.

stands out because it is so clear that the provision does not grant plan participants a legal right to an independent review, a fact the Hawai`i court's analysis failed to mention. Likewise, some other active-enforcement states appear to invest some discretion in the regulator concerning whether to grant an independent review, and over the form of review to be provided. These plans are too extensive to be subjected to the simple *Rush Prudential* test satisfactorily.

Hawai`i conceived an external review procedure that is connected with medical evidence and benefit determinations only insofar as Hawaii's insurance commissioner deems necessary to discover and correct any efforts of managed care plans to avoid mandated and promised benefits. Hawai`i's commissioner has discretion to grant a review of coverage denials on a case-by-case basis, and to choose from 3 alternative settings: summary disposition which may or may not include a consultation by a medical expert; submission of the case to an independent review organization; and a contested case hearing before a three-member panel the commissioner appoints to hear the case. *See* HRS § 432E-6, App., infra, at 47a-50a.

The Hawai`i court omitted discussion of the fact that Hawai`i's consumers do not enjoy a right to an independent review, or that 47% of the requests for review were rejected between July 1, 2000 and June 30, 2004 (after eliminating cases rejected on jurisdictional grounds because they involved federal plans). Only 23% of the remaining cases were submitted to a three-member panel for a hearing during that period. [24]

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[24] The failure to comply with the 60-day deadline for filing a request resulted in the rejection of 6% of the requests, 12% were withdrawn, and 12% of cases remained pending on June 30, 2004.
Annual External Review Report to Legislature (Years 2001-2004), required by HRS § 432E-13. *See, i.e.*, App., infra, at 97a-98a.

A. Standard Interpretation Required Consideration of Essential Aspects of HRS § 432E-6 Which the Hawai`i Court Omitted

The law the Hawai`i Supreme Court held cannot survive *Pilot Life*'s categorical bar[25] does not closely resemble the external review provision that is found in the Hawaii Revised Statutes at HRS § 432E-6. This is revealed in the court's analysis of the similarities and differences between HRS § 432E-6 and § 4-10. The court's observed similarities are all correct: Both statutes provide for an independent review of an insurer's denial of benefits, require consideration of medical necessity, and allow the reviewer to overturn the coverage denial. Both statutes grant the reviewer limited authority to interpret the insurance contract terms, and neither statute enlarges a claim for benefits beyond that available under no claim for relief § 1132(a). The court also determined that neither HRS § 432E-6 nor § 4-10 creates a claim for relief upon which a participant may file a lawsuit, a fact essential to the correct construction of HRS § 432E-6 in considering whether it is, in fact, preempted.

Of course, the Hawai`i court correctly held that "HRS § 432E-6 is saved by the saving clause in 29 U.S.C.S. § 1144(b)(2)(A) because it meets the two-part test in *Kentucky Ass'n of Health Plans, Inc. v. Miller*." App., *infra*, at 12a. HRS § 432E-6 is part of an integrated compliance scheme meeting the two-part *Miller* test. A review of the *Miller* test discussion in *Rush Prudential* serves to illustrate how much more readily it fits Hawai`i's more comprehensive Chapter 432E than § 4-10. The Illinois passive approach offers no clear assurance that providing participants with an enforceable right to an independent review will affect compliance. Providing Hawai`i's commissioner with the means to attract complaints and vari-

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[25] "We hold that HRS § 432E-6, a law that 'regulates insurance,' conflicts with § 1132(a) because HRS § 432E-6 'so resembles an adjudication as to fall within Pilot Life's categorical bar.' Rush Prudential, 536 U.S. at 381." App., *infra*, at 21a

ous alternatives to examine plan conduct in those cases is more certain to result in increased compliance. The express incorporation of the commissioner's powers to sanction managed care plans of all descriptions pursuant to the unfair insurance practices provisions at HRS § 431-13 serves to further emphasize the regulatory inspiration of the provision. Proper analysis of HRS § 432E-6 required that the Hawai`i court examine it in context, and discuss the substantial differences from § 4-10. Proper analysis would also, of course, have required reconciling the appropriateness of applying the identical test in both cases.

i. The Hawai`i Court Simply Ignored the Plain Language of the Statute

The differences the Hawai`i court noted between § 4-10 and HRS § 432E-6 are also correct, as far as they go. The court noted that HRS § 432E-6 provides for a three-member panel, only one of whom must be a physician, whereas § 4-10 consigns the determination to a single physician. The court failed to note the fact that the commissioner has complete discretion to choose from among at least two alternatives to the three-member panel, one of which is the same as the independent review § 4-10 provides. HRS § 432E-6(a)(2), App., *infra*, at 47a.

Furthermore, the facts do not sustain an implication of excessive legislative zeal to create an elaborate adjudicative process. Nothing suggests the health plan industry's influence in the political process more than its successful lobbying for a permanent seat in the deliberations in the cases the commissioner selects for review by a three-member panel. The Hawai`i court should have been more suspicious of the peculiar requirement for the panel to include one plan representative in its criticism of the three-member panel provision. App., *infra*, at 25a.

The Hawai`i court's inappropriate application of the *Rush Prudential* test also involved its concern over the right to judicial review from the three-member hearing. *Id.* Certainly, the hard compliance questions are properly consigned to an adversarial hearing because they may

involve significant consumer interests on the one hand, and significant property on the other. In those select cases, Hawai`i's constitution mandates that the commissioner's ultimate determination be subject to judicial review. The court's determination that the right to such review is "fatal" to HRS § 432E-6 brings constitutional due process rights into conflict with federal preemption unnecessarily because the statute does not provide a right to have an adversarial hearing.

The Hawai`i court's determination that HRS § 432E-6 provides an alternative cause of action and "the right of either party to seek judicial review. . ." App., *infra*, at 26a, collapses in light of the commissioner's discretion to reject a request for review, or to channel it to one of the alternatives from which there is no right to judicial review. App., *infra*, at 47a. The court's conclusion that "a claimant who is denied benefits pursuant to Hawaii's external review law can appeal that denial to the courts, allowing for a judicial determination of the claimant's entitlement to benefits. . . ." was therefore simply wrong.

The Hawai`i court's strike against HRS § 432E-6 directly conflicts with the Maryland high court's holding , discussed *infra*, that its commissioner's broad powers in connection with benefit determinations by ERISA plans are not preempted. The court's strike was not limited to the three-member panel process, but carried with it the whole of HRS § 432E-6, including the commissioner's discretion to send external reviews to an independent review organization or to make summary determinations; to assess fees and costs against plans; and the incorporation of the aforementioned unfair insurance practices provisions into the regulation of managed care plans with respect to ERISA participants. Further, the court's holding that ERISA preempted the commissioner's jurisdiction to award attorneys' fees and costs under HRS § 432E-6(e), the basis of HMAA's appeal, seems merely to flow from the determination that ERISA entirely preempts his jurisdiction to have anything to do with benefit determinations in ERISA plans. The justification for this authority

is apparent, as the commissioner's docket would almost certainly be forever bare if he lacked discretion to remove burdens inherent in his selection of cases for adversarial review. The court simply held that "[b]ecause. . . the Commissioner did not have jurisdiction to consider Baldado's claim[, he][.] [c]orrespondingly . . . did not have jurisdiction to award attorneys' fees and costs to Baldado. App., *infra*, at 26a. Absent from this analysis is any consideration of the fact that the commissioner's discretion to award attorneys' fees is not inconsistent with his general power to assess sanctions as part of the regulatory function in policing compliance, and his power to assess such sanctions against ERISA plans is surely beyond question. The short shrift the Hawai`i court gave to the central question of the appeal is thus at least very disappointing.

B. The Hawai`i Court Misread HRS § 432E-6 Because It Failed to Take Notice of Publicly Available Facts Disclosing the Agency's Interpretation of the Law

Act 137 amended Chapter 432E to require the commissioner to report to the Legislature annually on the number of external review hearing cases reviewed, their type, a summary of the nature of the cases, and their dispositions, a requirement that was codified at HRS § 432E-13. App., *infra*, at 50a, 62a. The court could therefore have taken notice of the following statistics, which were in the public record and within the knowledge

of anyone interested in the information:[26]

REQUESTS FOR EXTERNAL REVIEW

	requests for review	heard by panel	Rejected
FY2000-2001	20	2	0
FY2001-2002	30	6	23
FY2002-2003	35	12	14
FY2003-2004	40	7	19
	125	27	56
		22%	**45%**

The introduction to each report leaves no doubt that the commissioner interprets the statute to afford him discretion to reject petitions: "If the Commissioner finds that there is good cause for a petition, a hearing is scheduled on the petition." App., *infra*, at 97a.

Also of record was the fact that HRS § 432E-6 was twice amended before the commissioner entered his various orders in this case. Certainly the language "may file a request. . ." HRS § 432E-6(a), taken together with "Upon receipt of the request and upon a showing of good cause . . ." HRS § 432E-6(a)(4), and the plain imposition of the commissioner's discretion to assign a request to an alternative process fairly invited inquiry into the extent to which petitioners had a right to eventually submit the issue for judicial review.

Although the Hawai`i court correctly determined that HRS § 432E-6 meets the two-part test of *Miller* and is therefore saved, a more thorough-going analysis would have revealed that HRS § 432E-6 simply does not belong in the realm of passive enforcement mechanisms like § 4-10 which grant all participants the legal right to an inde-

[26] Compiled from the four Annual External Review Report to Legislature (Years 2001-2004), required by HRS § 432E-13.

pendent benefit determination, and therefore it was inappropriate to subject it to the *Pilot Life* and *Rush Prudential* analyses. The decision conflicts with at least one state court's holding that ERISA does not preempt the use of adversarial processes in an active enforcement scheme, even where constitutional due process concerns mandate a right to judicial review.

II. This Court Should Resolve the Conflict on the Application of the *Rush Prudential* Test to the States' Use of Adversarial Hearings to Regulate Compliance Because the Question Will Recur

The Hawai`i court's decision in this case cannot be reconciled with the opinion of the Maryland Court of Appeals in *Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md.*, 371 Md. 455, 810 A.2d 425 (2002),[27] reviewing a decision by the Baltimore circuit court that ERISA preempted the Maryland insurance commissioner's order to Connecticut General Ins. and CIGNA to pay benefits in external review cases and fines for failing to comply with the law. *Id.* at 461-62. Maryland's Appeals and Grievance Law, codified at Title 15, Subtitle 10A of the Maryland Insurance Article, Md. Code Ann., Ins., §§ 15-10A-01 *et seq.*,[28] were enacted with the goal of correcting perceived problems within the insurance industry regarding denial of benefits by insurers based on utilization reviews. *Conn. Gen.*, 371 Md. at 468, 810 A.2d at 432. Maryland provides its commissioner with a comprehensive regulatory authority. App., *infra*, at 87a. Like Hawai`i's commissioner, Maryland's commissioner has the authority to review benefit determinations in consultation with a medical expert or by referring the case to an independent review organization. App., *infra*, at 88a. The commissioner may order a reversal of the benefit denial and may assess fines and penalties against the plan. *Conn. Gen.*, 371 Md. at 471, 810 A.2d at 434. The Maryland high court noted

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[27] *Cert. dismissed*, 538 U.S. 1027, 123 S. Ct. 1964, 155 L. Ed. 2d 876 (2003), on motion of the parties.

[28] App., *infra*, at 86a-89a.

that the commissioner assessed Connecticut General $125,000 in one case and $2,500 in another for failure to comply with the internal appeals sections of the law. *Conn. Gen.*, 371 Md. at 461-62.

Once Maryland's commissioner issues an order in connection with the external review, all parties are given the opportunity to request an administrative hearing pursuant to Md. Code Ann., Ins., § 2-210A-01. § 15-10A-04(a). App., *infra*, at 86a. The relevant provisions of Maryland law provide procedural alternatives consistent in many respects with the Federal APA, including the right of judicial review. The court in *Mehrling v. Nationwide Ins. Co.*[29] gave an overview of the procedures and statutes implicated in requesting an administrative hearing from the commissioner's determination. For purposes of this case, it is sufficient to note that Hawai`i's procedures under the Hawaii Administrative Procedure Act[30] are no more complicated or onerous than Maryland's.

CIGNA and Connecticut General vigorously pursued an appeal to the Baltimore circuit court. *Conn. Gen.*, 371 Md. at 461-62. CIGNA also demanded an administrative hearing to argue that Maryland's law was preempted by ERISA because its procedures were so elaborate and onerous that they might undermine § 1132(a). *Larsen v. Cigna Healthcare Mid-Atlantic, Inc.*, 224 F. Supp. 2d 998, 1002 (D. Md. 2002). CIGNA then removed the administrative action to the U.S. District Court for the District of Maryland before a hearing was held, and also filed an action for declaratory judgment that ERISA completely preempted Maryland's Appeals and Grievance Laws. *Id.* at 1000. The district court dismissed the declaratory action and granted the commissioner's remand motion. *Id.* at 1010.

The Maryland Court of Appeals granted certiorari on its own motion from the Baltimore circuit court's holding that ERISA preempted the commissioner's authority to

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[29] 371 Md. 40, 51, 806 A.2d 662, 669 (2002)

[30] App., *infra*, at 84a-85a.

enforce state laws requiring Connecticut General to pay plan benefits, *id.* at 1003, and reversed the Baltimore circuit court's preemption decision and assessed costs against Connecticut General. *Conn. Gen.*, 371 Md. at 473. Maryland's high court found that Maryland's "external review process determines only whether the insurer has violated the terms of the health insurance contract in denying coverage." *Id.* at 470. The court relied on the language of *Rush Prudential* providing that while the external review process "may well settle the fate of a benefit claim under a particular contract, [but] the state statute does not enlarge the claim beyond the benefits available in any action brought under § 1132(a). . . ." *Id.* at 472.

In contrast to the Hawai`i court's analysis, the Maryland court took no issue with the fact that Maryland's law provides all parties in an external review the right to request an administrative hearing pursuant to Md. Code Ann., Ins., § 2-210A-01,[31] and judicial review, such as the review by the Baltimore circuit court from which the court granted certiorari. The two state courts, both reading *Rush Prudential*, came to results that are diametrically opposed.

The external reviews of other states are implicated by this controversy. Some processes belong to the realm of § 4-10 in which the state provides a legal right to external review in a passive enforcement approach.[32] The processes of the remaining states are more directly implicated because, as in Hawai`i, the external review process is committed directly to a state agency for management,

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[31] App., *infra*, at 86a.

[32] Arizona, California, Connecticut, Iowa, Louisiana, Maine, Minnesota, Montana, New Jersey, New York, North Carolina, Ohio, Oregon, South Carolina, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin all provide a statutory right to external review. Alaska, Iowa, Kansas, Kentucky, Pennsylvania, Rhode Island, and Tennessee also expressly provide the right to judicial enforcement and review. The right to external review in Georgia is restricted to claims of $500 or more, and Oklahoma sets the minimum at $1,000.

and the external review is part of an active regulatory design.

Among the active enforcement states, Missouri had passed comprehensive legislation to regulate managed care in 1997 before Hawai`i enacted Act 178. Missouri provided for an external review with the right to judicial review of the determination. Mo. Rev. Stat. § 376.1387.[33] As is the case in Hawai`i, the application for external review is made to Missouri's Director of Insurance, who is accorded complete discretion to determine the process the participant may have. The Missouri director's determinations may be appealed to court under the Missouri administrative law. The Missouri Court of Appeals questioned whether the abuse of discretion standard of review applicable to the director's decisions comports with due process under the Missouri constitution. *Hundley v. Wenzel*, 59 S.W.3d 1, 6 (Mo. Ct. App., 2001)(reversing director's decision upholding plan's denial). The Missouri court did not question the right to review and the opinion does not discuss ERISA. In light of the Hawai`i court's concerns with judicial review, it is notable that the court in *Hundley* conducted its own extensive review of the entire record that had been before the director before concluding that his decision upholding the benefit denial was arbitrary and capricious. The Missouri law's vulnerability to ERISA preemption has been discussed. Gretchen Garrison, *House Bill 335-Managed Care In Missouri,* 66 UMKC L. Rev. 775, 797 (1998).

New Mexico's Patient Protection Act became effective in July 1998, around the time Hawai`i's Patient Bill of Rights and Responsibilities was signed into law. New Mexico provides private remedies to enforce patient and provider insurance rights, and allows recovery of the greater of actual damages or $ 100, and injunctive relief. App., *infra*, at 90a. Any insured may file a complaint with the New Mexico superintendent of insurance based upon a coverage denial, and is thereby entitled to a hear-

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[33] App., *infra*, at 89a.

ing. App., *infra*, at 90a. The superintendent appears to have significant discretion to determine the type of hearing that is afforded, but his regulations, 13.10.17.30 NMAC, provide for hearings by a 3-member panel the superintendent selects consisting of an attorney, a physician, and one other person. App., *infra*, at 92a. A right to judicial review lies from hearings held under NMAC § 59A-4-15 pursuant to N.M. Stat. Ann. § 59A-4-20. App., *infra*, at 93a. Plans are responsible for the costs of the hearing, including the fees of the adjudicators, set by the superintendent. N.M. Stat. Ann. § 59A-57-4.1.D.[34]

Delaware also enacted a section now referred to as Delaware Patient's Bill of Rights, which became law July 18, 2000. 16 Del. C. § 9119 (2005).[35] In medical necessity cases, covered persons may apply for a review by the Independent Health Care Appeals Program in the Department of Health & Social Services, for a review by an independent utilization review organization ("IURO"). *Id.* Reviews in cases not involving medical necessity are referred to the Department of Insurance. *Id.* Health carriers may appeal decisions to superior court, but the appeal appears to be in the nature of a declaratory action as the statute does not permit reversal of the IURO's coverage determination. App., *infra*, at 94a.

Michigan's Patient's Right to Independent Review Act, Mich. Comp. Laws 500.2026(1)(b),[36] took effect on October 1, 2000, replacing and incorporating the 1997 Bill of Patient's Rights Act that required plans to have internal review processes.[37] Michigan also grounded the external review in its insurance commissioners' authority and provides some discretion to determine whether to reject a request for review. MCL 550.1911(3).[38] The Michigan process is a multi-level review process, and ei-

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[34] App., *infra*, at 90a.
[35] App., *infra*, at 93a.
[36] App., *infra*, at 95a.
[37] MCL 500.2213.
[38] App., *infra*, at 95a.

ther party may seek judicial review of the commissioner's determination. MCL 550.1915(1).[39]

In addition to Maryland, Missouri, New Mexico, Delaware, and Michigan have a direct interest in this Court's review of the Hawai`i court's decision in this case. The limitations discussed herein which the Hawai`i court failed to note, providing external review as part of an active regulatory plan and the absence of a right to judicial review in all cases, are common to the statutory schemes in each case. Like Hawai`i, these five states have put comprehensive programs in place to ensure compliance with medical necessity and other benefit mandates. The provision for external review in each case is integral to ensuring that instances of non-compliance are brought to the attention of the delegated authorities. It would be remarkable and probably unconstitutional for there to be no resort to judicial review from regulatory decisions.

It can be expected that the Hawai`i court's interpretation that ERISA preempts HRS § 432E-6 because Hawai`i law provides the right of judicial review from the agency determinations will arise in litigation in the other states, as the record shows that discussions in New Mexico and Michigan were underway before the opinion in this case was announced; and insurers in Maryland may see in the case new arguments on which to base an ERISA challenge. Thus this case presents questions of federal interpretation that should be addressed both for their potential impact on the other states and because it appears that the Hawai`i court would have decided that Maryland's external review law is preempted and thus there is a conflict between the two decisions.

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[39] App., *infra*, at 96a. The PRIRA's vulnerability to preemption is discussed by Eric J.Wexler, *Health Law: A Patient's Right to Independent Review: Has Michigan's Act Changed After Rush Prudential HMO, Inc v Moran?*, 81 Mich B J 18 (2002).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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Counsel for Petitioner

IN THE CIRCUIT COURT OF THE FIRST CIRCUIT, STATE OF HAWAII

HAWAII MANAGEMENT ALLIANCE ASSOCIATION, Appellant vs. THE INSURANCE COMMISSIONER and the DIVISION OF INSURANCE, of the DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAII; and KEVIN BALDADO, Appellees.	CIVIL NO. 01-1 -1 061 (Agency Appeal) DECISION AND ORDER AFFIRMING COMMISSIONER'S FINAL ORDERS HEARING: DATE: August 6, 2001 TIME: 11:00 a.m. JUDGE: Hon. Eden Elizabeth Hifo

DECISION AND ORDER AFFIRMING COMMISSIONER' S FINAL ORDERS

This matter came on for hearing before the Honorable Eden Elizabeth Hifo, Circuit Court Judge, at 11:00 A.M. on August 6, 2001, for oral argument on the appeal, pursuant to Hawaii Revised Statutes ("HRS") § 91-14 (a) and Haw. R. Civ. P. 72, by Appellant Hawaii Management Alliance Association ("HMAA"), from the Commissioner's Final Orders entered in In the Matter of the Claim of Kevin Baldado v. Hawaii Management Association, Insurance Division, Department of Commerce and Consumer Affairs, PR-01-003. The foregoing orders involved the Order Granting Attorney's Fees And Costs filed on March 1, 2001, see Certified Record on Appeal ("RA") at p. 314, and the Order Denying Respondent's Motion for Reconsideration filed on March 22, 2001, see PA at p. 326 (collectively 'Final Orders").

Appellant HMAA appeared by Ellen Godbey Carson, Esq., and Appellee KEVIN BALDADO ("BALDADO") ap-

peared by Thomas E. Bush, Esq. Appellee Insurance Commissioner ("COMMISSIONER") and Appellee Insurance Division ("DIVISION") of the Department of Commerce and Consumer Affairs, State of Hawaii, are parties to this appeal pursuant to Haw. R. Civ. P. 72(a), and appeared by James C. Paige, Deputy Attorney General.

The Court has heard and considered the oral arguments and written briefs submitted by counsel, and has reviewed the Certified Record on Appeal, and is in all respects fully informed in the matter.

The principal and dispositive issues on this appeal are Appellant HMAA's assertions that:

a) HRS § 432E-6 is preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101 et seq., when applied to employee health plans governed by ERISA; and

b) The COMMISSIONER erred when he awarded attorney's fees and costs to Appellee BALDADO and against Appellant HMAA pursuant to HRS § 432E—6(e).

The Court finds and concludes that:

1) HRS § 432E—6 is not preempted by ERISA; and

2) The COMMISSIONER did not err when he awarded attorney's fees and costs to Appellee BALDADO and against Appellant HMAA pursuant to HRS § 432E-6(e).

Therefore,

IT IS HEREBY ORDERED that for the reasons set forth above, the Commissioner's Final Orders, dated March 1, 2001 and March 22, 2001, entered in In the Matter of the Claim of Kevin Baldado V. Hawaii Management Association, Insurance Division, Department of Commerce and Consumer Affairs, PR-01-003, are hereby AFFIRMED. There are no other claims and no other parties to this HRS Chapter 91 appeal proceeding.

DATED: Honolulu, Hawai`i, Dec 04 2001

/s EDEN ELIZABETH HIFO
EDEN ELIZABETH HIFO
CIRCUIT COURT JUDGE
{SEAL}
FIRST CIRCUIT COURT
SEAL
STATE OF HAWAI`I

APPROVED AS TO FORM:
/s Ellen Godbey Carson
ELLEN GODBEY CARSON, ESQ.
Attorney for Appellant
HAWAII MANAGEMENT ALLIANCE
ASSOCIATION

/s Thomas E. Bush
Attorney for Appellee
KEVIN BALDADO
THOMAS E. BUSH, ESQ.

[HAWAII MANAGEMENT ALLIANCE ASSOCIATION v. INSURANCE COMMISSIONER AND THE DIVISION OF INSURANCE OF THE DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAII, AND KEVIN BALDADO, Civil No. 01-1-1061-04; ORDER]

IN THE CIRCUIT COURT OF THE FIRST CIRCUIT, STATE OF HAWAII

HAWAII MANAGEMENT ALLIANCE ASSOCIATION, Appellant vs. THE INSURANCE COMMISSIONER and the DIVISION OF INSURANCE, of the DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAII; and KEVIN BALDADO, Appellees.	CIVIL NO. 01-1 -1 061 (Agency Appeal) NOTICE OF ENTRY OF JUDGMENT

NOTICE OF ENTRY OF JUDGMENT

Pursuant to the provisions of the Hawaii Rules of Civil Procedure, Rule 77(d), NOTICE IS HEREBY GIVEN of the entry Of JUDGMENT, in the above-entitled cause

DATED: Honolulu, Hawai`i, Feb 04 2002

/s R. HIGA
Clerk of the above-entitled Court

{SEAL}
FIRST CIRCUIT COURT
SEAL
STATE OF HAWAI`I

Copies mailed to: (at last known address)

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* * * FOR PUBLICATION * * *

IN THE SUPREME COURT OF THE STATE OF HAWAI`I

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HAWAII MANAGEMENT ALLIANCE ASSOCIATION,
Appellant-Appellant,

vs.

THE INSURANCE COMMISSIONER and the DIVISION OF INSURANCE of the DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAI`I; and KEVIN BALDADO,
Appellees-Appellees.

NO. 24801

APPEAL FROM THE FIRST CIRCUIT COURT
(CIV. NO. 01-1-1061)
DECEMBER 16, 2004

MOON, C.J., LEVINSON, NAKAYAMA, ACOBA, AND DUFFY, JJ.

AMENDED OPINION OF THE COURT BY DUFFY, J.

Appellant-appellant Hawaii Management Alliance Association (HMAA) appeals from the February 4, 2002 judgment of the first circuit court, the Honorable Eden Elizabeth Hifo presiding, in which the circuit court affirmed the March 1, 2001 and March 22, 2001 orders of

the Insurance Commissioner of the Insurance Division, Department of Commerce and Consumer Affairs (Commissioner). The Commissioner had ordered an award of attorneys' fees and costs totaling $12,462.99 to be paid by HMAA to the attorneys representing appellee-appellee Kevin Baldado (Baldado); the circuit court concluded that the Commissioner did not err in awarding attorneys' fees and costs to Baldado, and HMAA appealed to this court.

HMAA contends that the Commissioner and the circuit court erred in awarding Baldado attorneys' fees and costs because the Employee Retirement Income Security Act of 1974 (ERISA) preempts Hawai`i Revised Statutes (HRS) § 432E-6, Hawaii's external review statute of the Patient's Bill of Rights and Responsibilities Act (HRS chapter 432E). HMAA also argues that the Commissioner and circuit court erred by failing to award HMAA attorneys' fees because Baldado's claim for coverage was an action in assumpsit and HMAA was the prevailing party.

We agree with HMAA's contention that ERISA preempts Hawaii's external review statute. Consequently, the circuit court's conclusions that Baldado was entitled to attorneys' fees and costs and that HMAA was not entitled to attorneys' fees and costs are void. We therefore vacate the Commissioner's March 1, 2001 order, the Commissioner's March 22, 2001 order, and the circuit court's February 4, 2002 judgment.

I. BACKGROUND

In September 2000, Baldado was diagnosed with metastatic renal carcinoma. Baldado's treating physician, William Loui, M.D., requested authorization from HMAA to perform a nonmyeloablative stem cell transplant to treat Baldado's cancer. HMAA denied Dr. Loui's request, stating that, "[a]ccording to National guidelines, stem cell transplant[s] [are] not covered for solid tumors . . . ." HMAA informed Baldado of his appeal rights and stated that if Baldado or Dr. Loui appealed, HMAA's Utilization Management Department would review the denial. Baldado exercised his appeal rights and submitted additional

information regarding stem cell transplants. In a letter dated January 23, 2001, HMAA upheld its denial, explaining that it denied the request because (1) Baldado's plan did not cover "investigational/ experimental procedure[s]"; (2) the service was not a covered benefit under federal government health plans; and (3) the service was not medically necessary. In a subsequent letter, HMAA informed Baldado that its medical director had recommended that HMAA deny Baldado's request. The letter also stated that with the medical director's denial, Baldado had exhausted all of HMAA's internal complaint and appeal procedures, but that HRS § 432E-6 (Supp. 2000) [1] provided for an external review of HMAA's determination by the Commissioner.

On February 15, 2001, Baldado filed a request for an expedited external review of HMAA's denial pursuant to HRS § 432E-6.5 (Supp. 2003). [2] In a letter dated February 15, 2001, the Commissioner informed HMAA of Baldado's request for an expedited external review and instructed HMAA to provide the Commissioner with documentation (specifically, the documents used to make HMAA's final internal determination, any documents submitted by Baldado, and a list of all individuals who provided health care to Baldado) within forty-eight hours of the date of the letter. In a letter dated February 16, 2001, HMAA timely responded to the Commissioner's request for documents and also provided a legal memorandum in response to Baldado's appeal. This legal memorandum included the argument that Hawaii's external review law, HRS § 432E-6, was unenforceable as to Baldado's ERISA-covered plan because ERISA preempted HRS § 432E-6. [3] On February 20, 2001, the Commissioner issued a decision and order [hereinafter, Commissioner's coverage order] concluding that Baldado failed to prove that HMAA's denial was improper. Therefore, the Commissioner's coverage order upheld HMAA's internal determination that Baldado was not entitled to coverage. The Commissioner's coverage order also included the following conclusion of law: "A managed care plan's final

internal determination is subject to external review, pursuant to HRS chapter 432E. As such, the review panel has jurisdiction over the subject external appeal." HMAA did not appeal the Commissioner's coverage order.

The Commissioner then notified Baldado that he may be entitled to reasonable attorneys' fees and costs under HRS § 432E-6(e). Baldado filed a request for $7,450 in attorneys' fees and $5,012.99 in costs (for the services of a medical consultant). HMAA filed a memorandum in opposition to Baldado's request in which HMAA argued that it, not Baldado, was entitled to attorneys' fees. On March 1, 2001, the Commissioner issued an order [hereinafter, Commissioner's attorneys' fees and costs order] awarding Baldado the attorneys' fees and costs he requested and directing HMAA to pay Baldado's attorney directly. HMAA filed a motion for reconsideration of the Commissioner's attorneys' fees and costs order; on March 22, 2001, the Commissioner denied the motion.

HMAA appealed to the circuit court; however, HMAA appealed only the Commissioner's attorneys' fees and costs order and the order denying HMAA's motion for reconsideration. HMAA did not appeal the Commissioner's coverage order.

In its opening brief to the circuit court, HMAA argued that: (1) HRS § 432E-6 is preempted by ERISA; (2) Baldado was not entitled to attorneys' fees and costs because he was not a prevailing party; (3) attorneys' fees and costs were incorrectly awarded against HMAA because it was the prevailing party; and (4) HMAA was entitled to attorneys' fees pursuant to HRS § 607-14 (Supp. 2000). On December 5, 2001, the circuit court filed its decision and order affirming the Commissioner's attorneys' fees and costs order and the Commissioner's March 22, 2001 order denying HMAA's motion for reconsideration. The circuit court found and concluded that HRS § 432E-6 is not preempted by ERISA and that the Commissioner did not err when he awarded attorneys' fees and costs to Baldado pursuant to HRS § 432E-6(e). On February 4, 2002, the circuit court entered judgment in favor of Baldado and

the Commissioner and against HMAA. On February 12, 2002, HMAA filed a timely appeal to this court.

II. STANDARDS OF REVIEW

A. Secondary Appeals

Review of a decision made by the circuit court upon its review of an agency's decision is a secondary appeal. The standard of review is one in which this court must determine whether the circuit court was right or wrong in its decision, applying the standards set forth in HRS § 91-14(g) [(1993)] to the agency's decision.

Korean Buddhist Dae Won Sa Temple of Hawaii v. Sullivan, 87 Hawai`i 217, 229, 953 P.2d 1315, 1327 (1998) (quoting Bragg v. State Farm Mutual Auto. Ins., 81 Hawai`i 302, 304, 916 P.2d 1203, 1205 (1996)) (alteration in original). HRS § 91-14, entitled "Judicial review of contested cases," provides in relevant part:

> (g) Upon review of the record the court may affirm the decision of the agency or remand the case with instructions for further proceedings; or it may reverse or modify the decision and order if the substantial rights of the petitioners may have been prejudiced because the administrative findings, conclusions, decisions, or orders are:
>
> (1) In violation of constitutional or statutory provisions; or
>
> (2) In excess of the statutory authority or jurisdiction of the agency; or
>
> (3) Made upon unlawful procedure; or
>
> (4) Affected by other error of law; or
>
> (5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
>
> (6) Arbitrary, or capricious, or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

"[U]nder HRS § 91-14(g), conclusions of law are reviewable under subsections (1), (2), and (4); questions regarding procedural defects under subsection (3); findings

of fact under subsection (5); and an agency's exercise of discretion under subsection (6)." In re Hawaiian Elec. Co., 81 Hawaii 459, 465, 918 P.2d 561, 567 (1996) (citing Outdoor Circle v. Harold K.L. Castle Trust Estate, 4 Haw.App. 633, 638-39, 675 P.2d 784, 789 (1983)).Paul's Elec. Serv., Inc. v. Befitel, 104 Hawai`i 412, 416-17, 91 P.3d 494, 498-99 (2004). B. Statutory Interpretation And Subject Matter Jurisdiction

This court has stated:

> We review the circuit court's interpretation of a statute de novo. State v. Pacheco, 96 Hawai`i 83, 94, 26 P.3d 572, 583 (2001). Our statutory construction is guided by established rules: When construing a statute, our foremost obligation is to ascertain and give effect to the intention of the legislature, which is to be obtained primarily from the language contained in the statute itself. And we must read statutory language in the context of the entire statute and construe it in a manner consistent with its purpose.
>
> . . . .

Id. at 94-95, 26 P.3d at 583-84.

Troyer v. Adams, 102 Hawai`i 399, 409, 77 P.3d 83, 93 (2003) (quoting Coon v. City & County of Honolulu, 98 Hawai`i 233, 245, 47 P.3d 348, 360 (2002)).

"Whether a court possesses subject matter jurisdiction is a question of law reviewable de novo." In re Doe Children: John, Born on January 27, 1987, & Jane, Born on July 31, 1988, minors, 105 Hawai`i 38, 52, 93 P.3d 1145, 1159 (2004) (citations and internal quotation signals omitted).

III. DISCUSSION

A. This Court Is Not Precluded from Reaching the Issue of ERISA Preemption.

Baldado and the Commissioner both argue that HMAA's arguments regarding ERISA preemption are precluded. Baldado argues that HMAA is precluded from raising the issue of ERISA preemption altogether because

HMAA did not appeal the Commissioner's coverage order (which denied coverage to Baldado but concluded that HMAA was subject to Hawaii's external review law.) The Commissioner, on the other hand, concedes that HMAA may contest ERISA's preemption of HRS § 432E-6(e) (the subsection of the external review law that gives the Commissioner the authority to grant attorneys' fees and costs), but argues that HMAA is precluded from arguing that ERISA preempts any other section of HRS § 432E-6.

We disagree with Baldado and the Commissioner. The Commissioner's authority to hear external review appeals, as well as the circuit court's authority to review the Commissioner's rulings stemming from those appeals, are questions of subject matter jurisdiction. See Int'l Bhd. of Painters & Allied Trades Local Union 1944 v. Befitel, 104 Hawai`i 275, 281, 88 P.3d 647, 653 (2004) ("'Subject matter jurisdiction is concerned with whether the court has the power to hear a case.'" (Quoting Pele Def. Fund v. Puna Geothermal Venture, 77 Hawai`i 64, 67, 881 P.2d 1210, 1213 (1994).)), recons. denied, 2004 Haw. LEXIS 376 (2004). And as we have stated, "[i]t is well-established . . . that lack of subject matter jurisdiction can never be waived by any party at any time." Chun v. Employees' Ret. Sys. of Hawai`i, 73 Haw. 9, 14, 828 P.2d 260, 263 (1992). See also Amantiad v. Odum, 90 Hawai`i 152, 159, 977 P.2d 160, 167 (1999) ("When reviewing a case where the circuit court lacked subject matter jurisdiction, the appellate court retains jurisdiction, not on the merits, but for the purpose of correcting the error in jurisdiction."). We therefore consider these questions because they address the subject matter jurisdiction of the Commissioner and the circuit court. [4]

B. HRS § 432E-6 Is Not Expressly Preempted.

Although ERISA expressly preempts state laws relating to the regulation of employee welfare benefit plans, this express preemption clause does not apply to state laws that "regulate[] insurance." 29 U.S.C. § 1144 (2000). As discussed in subsection 1, infra, all state statutes that relate to employee benefit plans are expressly preempted

pursuant to 29 U.S.C. § 1144(a). Because HRS § 432E-6 is a state statute that relates to employee benefit plans, ERISA appears, at first glance, to preempt HRS § 432E-6. Nevertheless, as discussed in subsection 2, infra, state statutes are "saved" from preemption if the statutes "regulate[] insurance." 29 U.S.C. § 1144(b)(2)(A). Consequently, we conclude that ERISA does not expressly preempt HRS § 432E-6. [5]

1. Baldado's health plan is an employee benefit plan subject to ERISA.

Baldado's health plan is an employee benefit plan within the scope of ERISA because it is a plan maintained by Baldado's employer. See 29 U.S.C. § 1003(a) (2000). [6] ERISA contains broad language preempting "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a) [7] (emphasis added). Thus, at first glance, ERISA appears to preempt HRS § 432E-6. As discussed in the following subsection, however, ERISA contains a saving clause for laws such as HRS § 432E-6 that "regulate[] insurance"; consequently, HRS § 432E-6 is not subject to ERISA's express preemption clause, § 1144(a).

2. HRS § 432E-6 "regulates insurance" and therefore is saved from express preemption.

A state law may be saved from direct preemption if the law "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). [8] We hold that HRS § 432E-6 "regulates insurance" and therefore is saved from express ERISA preemption. Furthermore, based on the United States Supreme Court's holdings in Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002), and Kentucky Ass'n of Health Plans, Inc. v. Miller, 538 U.S. 329 (2003), we reject HMAA's arguments for preemption.

HRS § 432E-6 is saved by the saving clause in 29 U.S.C. § 1144(b)(2)(A) because it meets the two-part test in Kentucky Ass'n of Health Plans, Inc. v. Miller. In Miller, the United States Supreme Court held:

> [F]or a state law to be deemed a "law . . . which regulates insurance" under § 1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See Pilot Life [Ins. Co. v. Dedaux, 481 U.S. 41, 50 (1987)], UNUM [Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368 (1999)]; Rush Prudential, supra, at 366. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured.

538 U.S. at 341-42 (some alterations in original and some added). [9]

As to the first part of the test -- that a state law must be "specifically directed toward entities engaged in insurance" -- Miller requires that a state law "impos[e] conditions on the right to engage in insurance" to deserve the protections of the saving clause. Id. at 338. The Hawai`i external review statute meets the first part of the Miller test because it is specifically directed toward entities engaged in insurance and it imposes conditions on the right to engage in the business of insurance in Hawai`i. Any insurer who wishes to provide health insurance must submit to an external review of its internal coverage or benefits determinations; if an insurer fails to comply with this requirement, the Commissioner may take away the insurer's license to conduct business in the state. [10] Thus, the Hawai`i law regulates insurance because the right to engage in business in Hawai`i is conditioned upon the insurer's submission to the external review procedure.

Hawaii's external review law, HRS 432E-6, also satisfies the second prong of the Miller test. The external review law alters the terms of insurance policies by creating an additional review process for an insurer's denial of coverage. This alteration of the terms of health insurance policies is more than sufficient to satisfy the second prong of the Miller test: as the Supreme Court stated, "We have never held that state laws must alter or control the actual terms of insurance policies to be deemed 'laws . . . which regulat[e] insurance' under § 1144(b)(2)(A); it suffices

that they substantially affect the risk pooling arrangement between insurer and insured." Miller, 538 U.S. at 338 (alterations in original). See also id. at 338-39 (stating that an Illinois independent review statute, similar to HRS § 432E-6 and upheld in Rush Prudential, 536 U.S. at 355, was a law that "regulate[d] insurance" because it "alter[ed] the scope of permissible bargains between insurers and insureds"). Like the "notice-prejudice" rule (which states that an insurer will not be relieved of liability based on an insured's untimely notice of a claim unless the insurer demonstrates that it has been prejudiced as a result of the late notice, see Standard Oil Co. of California v. Hawaiian Ins. & Guar. Co., Ltd., 65 Haw. 521, 526 n.4, 654 P.2d 1345, 1348 n.4 (1982)), the external review law "dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured." Miller, 538 U.S. at 339 n.3 (citing UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358, 368 (1999) (holding that California's "notice-prejudice" rule "regulate[d] insurance" for the purposes of ERISA's saving clause)). If an insurer denies coverage for a particular medical procedure, the insurer must be prepared to participate in an external review procedure upon request by the insured; insurers who do not comply with this requirement risk losing their licenses or certificates of authority to engage in the business of insurance in Hawai`i. HRS § 431:2-203(c) (Supp. 2003) (providing that if an insurance licensee "persistently or substantially violates . . . an order of the commissioner, . . . the commissioner may, . . . in whole or in part, suspend, place on probation, limit or refuse to renew the license or certificate of authority").

HMAA argues that HRS § 432E-6 is not covered by the saving clause because (1) HMAA is not an insurance company regulated under Hawaii's insurance code (HRS chapter 431) and (2) HRS § 432E-6 regulates health care as well as insurance. HMAA's arguments were addressed and rejected by the United States Supreme Court in Rush

Prudential. In Rush Prudential, the health maintenance organization (HMO) involved argued that the state statute at issue was not saved from ERISA preemption because (1) the HMO was a health care provider as well as an insurer, and (2) the statute affected both insurance and noninsurance activities. Rush Prudential, 536 U.S. at 366, 370. The Rush Prudential Court did not find the HMO's arguments persuasive. In addressing the HMO's first argument, the Court stated that an HMO is both a health care provider and an insurer: there was "[n]othing in the saving clause requires an either-or choice between health care and insurance in deciding a preemption question, and as long as providing insurance fairly accounts for the application of state law, the saving clause may apply." Id. at 367. In addressing the second argument, the Court concluded that the possibility that the state statute could affect noninsurers was not enough "to remove a state law entirely from the category of insurance regulation saved from preemption." Id. at 372. Therefore, under a reading of Rush Prudential, HMAA's arguments are not persuasive.

Based on the foregoing, we hold that HRS § 432E-6, as a law that "regulates insurance," is not expressly preempted by ERISA.

C. HRS § 432E-6 Is Impliedly Preempted By ERISA's Civil Enforcement Remedy.

Even though HRS § 432E-6 "regulates insurance" pursuant to § 1144(b)(2)(A), Hawaii's external review law will nevertheless be deemed preempted if it conflicts with ERISA's civil enforcement scheme, 29 U.S.C. § 1132(a) (2000) [hereinafter, § 1132(a)]. [11] Based on the following, we hold that ERISA preempts Hawaii's external review law and that Hawaii's external review law is therefore unenforceable. In subsection 1, we define the two types of implied preemption: "field" preemption and "conflict" preemption. In subsection 2, we examine field preemption as applied to ERISA. And in subsection 3, we examine conflict preemption as applied to ERISA, focusing the discussion on conflict preemption as applied to state laws that

"regulate[] insurance" and concluding that HRS § 432E-6 is preempted by ERISA. Consequently, we hold that the circuit court erred in affirming the Commissioner's award of attorneys' fees.

1. The Doctrine of Implied Preemption

As the United States Supreme Court has stated:

> We have recognized that a federal statute implicitly overrides state law either when the scope of a statute indicates that Congress intended federal law to occupy a field exclusively, English v. General Elec. Co., 496 U.S. 72, 78-79 (1990), or when state law is in actual conflict with federal law. We have found implied conflict pre-emption where it is "impossible for a private party to comply with both state and federal requirements," id., at 79, or where state law "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." Hines v. Davidowitz, 312 U.S. 52, 67 (1941).

Freightliner Corp. v. Myrick, 514 U.S. 280, 287 (1995). Thus, HRS § 432E-6 will be deemed preempted if it conflicts with § 1132(a) ("conflict" preemption) or if Congress intended ERISA to occupy the entire field of HMO regulation ("field" preemption). Cf. Casumpang v. ILWU, Local 142, 94 Hawai`i 330, 339, 13 P.3d 1235, 1244 (2000) ("Traditionally, federal preemption cases have been grouped into three categories: (1) express preemption; (2) implied preemption; and (3) conflict preemption.").

2. Implied field preemption as applied to ERISA

ERISA's express preemption and saving clauses demonstrate that ERISA does not impliedly preempt the entire field of HMO regulation. As the United States Supreme Court has stated:

> When Congress has considered the issue of pre-emption and has included in the enacted legislation a provision explicitly addressing that issue, and when that provision provides a reliable indicium of congressional intent with respect to

> state authority, there is no need to infer congressional intent to pre-empt state laws from the substantive provisions of the legislation. Such reasoning is a variant of the familiar principle of expressio unius est exclusio alterius: Congress' enactment of a provision defining the pre-emptive reach of a statute implies that matters beyond that reach are not pre-empted.

Cipollone v. Liggett Group, Inc., 505 U.S. 504, 517 (1992) (citations and internal quotation signals omitted). See also Rush Prudential, 536 U.S. at 365 ("[T]he historic police powers of the States were not [meant] to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." (Citations and internal quotation signals omitted.) (Second alteration in original.)). That ERISA contains an express preemption clause and a saving clause demonstrates that Congress did not intend ERISA to occupy the entire field of HMO regulation. Furthermore, in Rush Prudential, the Supreme Court held that a state law regulating the insurance features of an HMO was saved by § 1144(b)(2)(A), even though the HMO in question contracted to provide medical services for an ERISA-covered employee welfare benefit plan. Rush Prudential, 536 U.S. at 359. Additionally, as the Supreme Court stated in English v. General Electric Co., 496 U.S. 72, 79 (1990):

> Although this Court has not hesitated to draw an inference of field pre-emption where it is supported by the federal statutory and regulatory schemes, it has emphasized: "Where . . . the field which Congress is said to have pre-empted" includes areas that have "been traditionally occupied by the States," congressional intent to supersede state laws must be "'clear and manifest.'"

(Quoting Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)).) Health care is "'a subject of traditional state regulation,'" Rush Prudential, 536 U.S. at 387 (quoting Pegram v. Herdrich, 530 U.S. 211, 237 (2000)); therefore, because we can find no clear and manifest con-

gressional intent to supersede state-law HMO regulations, we hold that implied field preemption does not apply to Hawaii's external review statute.

3. Conflict preemption as applied to ERISA

Although the existence of express preemption and saving clauses indicates that Congress did not intend to preempt the entire field of HMO regulation, the existence of these clauses does not necessarily mean that conflict preemption cannot exist. See Aetna Health Inc. v. Davila, ___ U.S. ___, ___, 124 S. Ct. 2488, 2500 (2004) (stating that "[U]nder ordinary principles of conflict pre-emption, . . . even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme."); Buckman Co. v. Plaintiffs' Legal Comm., 531 U.S. 341, 352 (2001) ("[N]either an express pre-emption provision nor a saving clause 'bar[s] the ordinary working of conflict pre-emption principles.'" (Quoting Geier v. Am. Honda Motor Co., 529 U.S. 861, 869 (2000).) (Second alteration in original.)). See also Geier, 529 U.S. at 869 (discussing the National Traffic and Motor Vehicle Safety Act of 1966 and stating that "[w]e now conclude that the saving clause (like the express pre-emption provision) does not bar the ordinary working of conflict pre-emption principles").

In Aetna Health, a unanimous Supreme Court held that a state statute was preempted because it conflicted with ERISA. At issue was a Texas statute that created a cause of action against HMOs for failure to exercise ordinary care in handling coverage decisions. Aetna Health, 124 S. Ct. at 2492-93. Justice Thomas, writing for the Court, stated that "[t]he purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans" and concluded that the statute was preempted because "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Id. at 2495. The Court further held that "[u]nder ordinary

principles of conflict pre-emption, . . . even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." Id. at 2500. Thus, according to Aetna Health, any state law that creates a claim for relief relating to an ERISA-regulated employee benefit plan necessarily conflicts with § 1132(a) and is therefore preempted. See id.

Although Aetna Health offers an expansive interpretation of the preemptive effects of § 1132(a), an earlier Supreme Court case, Rush Prudential, 536 U.S. at 365-87, strongly suggests that some state laws that "regulate[] insurance," such as HRS § 432E-6, survive § 1132(a)'s preemptive scope. Given Aetna Health's expansive language, whether Rush Prudential survives Aetna Health is not entirely clear.

In the remainder of this subsection, we first examine Rush Prudential, a case involving a state-mandated regulatory scheme similar to HRS § 432E-6 (see subsection a, infra). We then attempt to reconcile Rush Prudential and Aetna Health; we conclude that Aetna Health prohibits the states from creating new claims for relief but allows the states to regulate insurance by creating additional procedural regulations for insurers (see subsection b, infra). Therefore, we hold that Rush Prudential survives Aetna Health. We then apply this analysis to HRS § 432E-6 and conclude that ERISA preempts Hawaii's external review law (see subsection c, infra).

a. Rush Prudential HMO, Inc. v. Moran

In Rush Prudential, the Supreme Court considered an Illinois statute similar to HRS § 432E-6. According to the Illinois statute, when an HMO denied a patient's claim for certain types of health care coverage, the HMO was required to honor the patient's request for an independent medical review of the patient's claim. Rush Prudential, 536 U.S. at 359, 361. The statute mandated that the independent medical review be done by "'a physician

holding the same class of license as the primary care physician, who is unaffiliated with the [HMO], jointly selected by the patient . . . , primary care physician and the [HMO].'" (12) Id. at 361 (quoting 215 Ill. Comp. Stat. 125/4-10 (2000) [hereinafter, § 4-10]) (ellipsis in original). The statute provided that "'[i]n the event that the reviewing physician determines the covered service to be medically necessary, the [HMO] shall provide the covered service.'" Id. (quoting § 4-10). The Court explained that the independent review statute was similar to arbitration in that the independent reviewer was entitled to consider the HMO contract in addition to evidence such as medical records; however, despite these similarities, the Court stated that § 4-10 "does not resemble either contract interpretation or evidentiary litigation before a neutral arbiter, as much as it looks like a practice (having nothing to do with arbitration) of obtaining another medical opinion." Id. at 382-83.

A divided Court upheld § 4-10. Justice Souter, writing for the Court, stated that the Illinois statute was not preempted because it did not create a new claim for relief:

> [T]his case addresses a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief. While independent review under § 4-10 may well settle the fate of a benefit claim under a particular contract, the state statute does not enlarge the claim beyond the benefits available in any action brought under § 1132(a). And although the reviewer's determination would presumably replace that of the HMO as to what is "medically necessary" under this contract, the relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a).

Id. at 379-80 (footnote omitted). The Rush Prudential Court recognized that allowing the states to establish these types of procedures would somewhat undermine ERISA's purpose in establishing a "uniform federal regime of 'rights and obligations' under ERISA." Id. at 381.

However, the Court stated, "'[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation.'" Id. (quoting Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985)) (alterations in original). The Court acknowledged its previous holding in Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 57 (1987) (holding that Congress had "clearly express[ed], through the structure and legislative history of . . . ERISA, an intention that the federal remedy . . . displace state causes of action") and explained that a state statute might "so resemble an adjudication as to fall within Pilot Life's categorical bar." Rush Prudential, 536 U.S. at 381. Nevertheless, the Court upheld the Illinois statute because the statute "does not implicate ERISA's enforcement scheme at all" and "imposes no new obligation or remedy."[(13)] Id. at 386.

Justice Thomas, joined by Chief Justice Rehnquist, Justice Scalia, and Justice Kennedy, dissented. Id. at 388. Justice Thomas (who later wrote for the Court in Aetna Health) argued that ERISA's civil enforcement scheme was intended to be exclusive: "Such exclusivity of remedies is necessary to further Congress' interest in establishing a uniform federal law of employee benefits so that employers are encouraged to provide benefits to their employees[.]" Id. He contended that § 4-10 was an alternative state-law remedy and that the Court had consistently held that such state-law remedies conflicted with ERISA's civil enforcement scheme. Id. at 393-94. He stated that, while the states are entitled to regulate health care, the states are not entitled to circumvent ERISA by creating alternative procedures like those in § 4-10:

> [W]ere a State to require that insurance companies provide all "medically necessary care" or even that it must provide a second opinion before denying benefits, I have little doubt that such substantive requirements would withstand ERISA's pre-emptive force. But recourse to those benefits, like all others, could be sought only through an action under § [1132] and not, as is the case here,

> through an arbitration-like remedial device. Section 4-10 does not, in any event, purport to extend a new substantive benefit. Rather, it merely sets up a procedure to conclusively determine whether the HMO's decision to deny benefits was correct when the parties disagree, a task that lies within the exclusive province of the courts through an action under § [1132(a)].

Id. at 399. Justice Thomas conceded that ERISA's saving clause allowed for some lack of uniformity, but stated that "[a]llowing disparate state laws that provide inconsistent external review requirements to govern a participant's or beneficiary's claim to benefits under an employee benefit plan is wholly destructive of Congress' expressly stated goal of uniformity in this area." Id. at 400-01.

b. Interpreting Rush Prudential in light of Aetna Health

The next question is whether Rush Prudential and Miller (discussed supra) survive Aetna Health; in other words, does ERISA's saving clause still have meaning, or are all state laws relating to employee benefit plans preempted by § 1132(a)? We believe that the United States Supreme Court's holding in Aetna Health was not intended to overrule Rush Prudential or Miller. Based on Aetna Health, Miller, and Rush Prudential, we believe that the Hawaii legislature may continue to "regulate[] insurance" so long as the legislature does not create a "cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy." Aetna Health, 124 S. Ct. at 2495. Reading Rush Prudential and Aetna Health together, we believe that the Supreme Court intended to distinguish between state laws that (1) create a state law claim for relief against an employee benefit plan and (2) require insurers to provide certain procedural protections to insureds (even if the insurance is provided as part of an ERISA-covered employee benefit plan).

Aetna Health struck down the state statute at issue because "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." Aetna Health, 124 S. Ct. at 2495. The Supreme Court has consistently struck down state laws that create claims for relief against ERISA-covered employee benefit plans, even if those state laws also regulate insurance. See, e.g., Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 135, 145 (1990) (holding that an employee's claim for relief for wrongful discharge based on state common law was preempted by § 1132(a)); Pilot Life, 481 U.S. at 57 (holding that a state common law claim for bad faith did not fall under the saving clause and was therefore preempted by § 1144(a)). As the United States Court of Appeals for the Third Circuit recently explained:

> Reading Pilot Life, Rush Prudential, and Aetna Health together, a state statute is preempted by ERISA if it provides "a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA," Rush Prudential, 536 U.S. at 379, 122 S.Ct. 2151, or stated another way, if it "duplicates, supplements, or supplants the ERISA civil enforcement remedy." Aetna Health, --- U.S. at ----, 124 S.Ct. at 2495 (citing Pilot Life, 481 U.S. at 54-56, 107 S.Ct. 1549).

Barber v. Unum Life Ins. Co. of Am., 383 F.3d 134, 140 (3d Cir. 2004).

In contrast, Rush Prudential upheld the state statute at issue because it was "a state regulatory scheme that provide[d] no new cause of action under state law and authorize[d] no new form of ultimate relief." Rush Prudential, 536 U.S. at 379. As Rush Prudential demonstrates, the Court has been careful not to "read the saving clause out of the statute." Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 747 (1985). Although the dissenting Justices in Rush Prudential argued that state insurance regulations would undermine congressional intent (by

corroding uniformity in the area of employee welfare benefit plans), the majority rejected this argument. Instead, the majority held that the states were entitled to require insurers to comply with certain procedural requirements as a condition of engaging in the business of insurance within the state's borders. See Rush Prudential, 536 U.S. at 379-80. Again, the Court limited states' power by stating that a state law would be preempted if it enlarged a claim for benefits beyond what was available pursuant to § 1132(a): "[T]he relief ultimately available would still be what ERISA authorizes in a suit for benefits under § 1132(a)." Id. at 380.

Thus, both Rush Prudential and Aetna Health hold that a state may not create a new "cause of action." (14) Both cases preserve the states' right to regulate insurance so long as those insurance regulations do not conflict with ERISA's civil enforcement scheme. In sum, Aetna Health does not overrule Rush Prudential. (15) Therefore, we hold that a state law that "regulates insurance" is not preempted so long as it does not create a new claim for relief and does not enlarge a claim for benefits beyond that available in § 1132(a).

The following subsection applies this principle to HRS § 432E-6.

c. Conflict preemption and HRS § 432E-6

We hold that HRS § 432E-6, a law that "regulates insurance," conflicts with § 1132(a) because HRS § 432E-6 "so resemble[s] an adjudication as to fall within Pilot Life's categorical bar." Rush Prudential, 536 U.S. at 381.

HRS § 432E-6 is very similar to the Illinois statute at issue in Rush Prudential: both statutes provide for an independent review of an insurer's denial of benefits; both statutes require the reviewing individual(s) to consider the medical necessity of the procedure at issue; and both statutes allow the reviewing individual(s) to overturn the insurer's denial of coverage. See HRS § 432E-6; 215 Ill. Comp. Stat. 125/4-10. Both statutes allow the reviewing individual(s) limited authority to interpret the terms of the insurance contract. See HRS § 432E-6(a)(7) (providing

that the review panel must consider "[t]he terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document" in determining whether the HMO acted reasonably); Rush Prudential, 536 U.S. at 380, 383 (stating that "the reviewer's determination would presumably replace that of the HMO as to what is 'medically necessary' under this contract" but recognizing that the Illinois statute "does not give the independent reviewer a free-ranging power to construe contract terms, but instead, confines review to . . . the phrase "medical necessity[]'"). Neither statute creates a claim for relief upon which an aggrieved beneficiary or participant can file a lawsuit, and neither statute enlarges a beneficiary's or participant's claim for benefits beyond what she or he could obtain pursuant to § 1132(a). See HRS § 432E-6; 215 Ill. Comp. Stat. 125/4-10.

Nevertheless, the Illinois statute and HRS § 432E-6 differ in several important ways. First, Hawai`i's external review incorporates HRS chapter 91, the Hawai`i Administrative Procedure Act (HAPA). See HRS § 432E-6(a)(4) (stating that "the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91"). HAPA sets forth the procedural requirements for contested case hearings, see, e.g., HRS § 91-9 (1993 & Supp. 2003) (providing that all parties in a contested case "shall be afforded an opportunity for hearing after reasonable notice"); more importantly, HAPA provides for judicial review of contested cases: "[a]ny person aggrieved by a final decision and order in a contested case . . . is entitled to judicial review thereof under this chapter[.]" HRS § 91-14 (1993). Second, whereas the Illinois statute considered in Rush Prudential required one physician to determine whether the proposed procedure was "medically necessary," the Hawai`i statute provides for a three-member panel (only one of whom must be a physician) to determine whether the HMO's actions were "reasonable."

These distinctions are fatal to the external review law. The external review hearing more closely resembles

"contract interpretation or evidentiary litigation before a neutral arbiter" than "a practice (having nothing to do with arbitration) of obtaining another medical opinion." Rush Prudential, 536 U.S. at 383. More damaging, however, is the right of either party to seek judicial review. For example, a claimant who is denied benefits pursuant to Hawaii's external review law can appeal that denial to the courts, allowing for a judicial determination of the claimant's entitlement to benefits. This is precisely the type of adjudication barred by Pilot Life, 481 U.S. at 52 (holding that § 1132(a) is the "exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits"). See HRS § 432E-6; 215 Ill. Comp. Stat. 125/4-10. Thus, although the Hawai`i legislature is entitled to regulate insurance by requiring external review (because external review laws are not necessarily preempted by ERISA), HRS § 432E-6 too closely resembles adjudication and therefore is preempted by § 1132(a). [16] We emphasize, however, that our holding applies only to those plans covered by ERISA: Hawaii's external review law continues to apply to those plans that are excluded from ERISA coverage. See 29 U.S.C. § 1003(b) (2000) (excluding, inter alia, governmental and church plans from ERISA coverage).

Because Hawaii's external review law is preempted, the Commissioner did not have jurisdiction to consider Baldado's claim. Correspondingly, the Commissioner did not have jurisdiction to award attorneys' fees and costs to Baldado, and the Commissioner's March 1, 2001 and March 22, 2001 orders are void. See Amantiad v. Odum, 90 Hawai`i 152, 159, 977 P.2d 160, 167 (1999) ("When reviewing a case where the circuit court lacked subject matter jurisdiction, the appellate court retains jurisdiction, not on the merits, but for the purpose of correcting the error in jurisdiction. A judgment rendered by a circuit court without subject matter jurisdiction is void." (Citations omitted.)). Similarly, the circuit court's conclusions that Baldado was entitled to attorneys' fees and costs and

that HMAA was not entitled to attorneys' fees and costs are void. See id.

IV. CONCLUSION

Based on the foregoing, we vacate the Commissioner's March 1, 2001 order, the Commissioner's March 22, 2001 order, and the circuit court's February 4, 2002 judgment.

On the briefs:

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1. HRS § 432E-6, entitled "External review procedure," provides in pertinent part:

> (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawai`i not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner within sixty days from the date of the final internal determination by the managed care plan;

(2) The commissioner may retain:

(A) Without regard to chapters 76 and 77, an independent medical expert trained in the field of medicine most appropriately related to the matter under review. Presentation of evidence for this purpose shall be exempt from section 91-9(g); and

(B) The services of an independent review organization from an approved list maintained by the commissioner;

(3) Within seven days after receipt of the request for external review, a managed care plan or its designee utilization review organization shall provide to the commissioner or the assigned independent review organization:

(A) Any documents or information used in making the final internal determination including the enrollee's medical records;

(B) Any documentation or written information submitted to the managed care plan in support of the enrollee's initial complaint; and

(C) A list of the names, addresses, and telephone numbers of each licensed health care provider who cared for the enrollee and who may have medical records relevant to the external review;

provided that where an expedited review is involved, the managed care plan or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review. Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the plan or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the managed care plan of the decision;

(4) Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

(5) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that:

(A) The hearing shall be held no later than sixty days from the date of the request for the hearing;

(B) An external review conducted as an expedited appeal shall be determined no later than seventy-two hours after receipt of the request for external review;

(6) After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed by the parties, the commissioner may dismiss the request for external review if it is determined that the request is frivolous or without merit; and

(7) The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably. The review panel and the commissioner or the commissioner's designee shall consider:

(A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;

(B) Whether the medical director properly applied the medical necessity criteria in section 432E-1.4 in making the final internal determination;

(C) All relevant medical records;

(D) The clinical standards of the plan;

(E) The information provided;

(F) The attending physician's recommendations; and

(G) Generally accepted practice guidelines.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

(c) No person shall serve on the review panel or in the independent review organization who, through a familial relationship within the second degree of consanguinity or affinity, or for other reasons, has a direct and substantial professional, financial, or personal interest in:

(1) The plan involved in the complaint, including an officer, director, or employee of the plan; or

(2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal drug, device, procedure, or other therapy at issue.

(d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative proceeding determines that the appeal was unreasonable, fraudulent, excessive, or frivolous.

2. HRS § 432E-6.5, entitled "Expedited appeal, when authorized; standard for decision," has not been amended since its insertion in 2000 and currently provides in pertinent part:

(a) An enrollee may request that the following be conducted as an expedited appeal:

. . . .

(2) The external review under section 432E-6 of the managed care plan's final internal determination.

If a request for expedited appeal is approved by the managed care plan or the commissioner, the appropriate review shall be completed within seventy-two hours of receipt of the request for expedited appeal.

(b) An expedited appeal shall be authorized if the application of the forty-five day standard review time frame may:

(1) Seriously jeopardize the life or health of the enrollee . . .

.

In other words, an enrollee in an insurance plan may request an expedited external review when the standard review time frame may "seriously jeopardize the life or health of the enrollee." The standard time frame is forty-five days, whereas the expedited appeal must be completed within seventy-two hours of the receipt of the request for an expedited appeal.

3. Specifically, HMAA argued that HRS § 432E-1 exempts employee benefit plans governed by ERISA and that a finding that HRS § 432E-6 applied would constitute unlawful state action. HMAA also argued that the federal courts had repeatedly held that ERISA preempts claims under state laws and that Hawaii's enforcement scheme directly interferes with the rights HMAA has under ERISA. In its legal memorandum, HMAA objected to the short notice and response time and stated that if the Commissioner took any adverse action on HMAA's coverage decision, HMAA would want the opportunity to have a full hearing and present witnesses. Furthermore, HMAA stated that the request for a full hearing and its filing of documents with the Commissioner did not demonstrate an intent to waive HMAA's position that Hawaii's external review law was not applicable to ERISA plans.

4. Consequently, we need not address whether res judicata or collateral estoppel precludes HMAA from arguing that ERISA preempts Hawaii's external review law.

5. However, as discussed in Section C, infra, we hold that ERISA does preempt HRS § 432E-6 because Hawaii's external review law conflicts with ERISA.

6. 29 U.S.C. § 1003, entitled "Coverage," provides in relevant part:

> (a) Except as provided in subsection (b) of this section and in section 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained—
>
> (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or
>
> (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or
>
> (3) by both.

7. 29 U.S.C. § 1144 provides in relevant part:

> (a) Supersedure; effective date
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

8. 29 U.S.C. § 1144(b)(2)(A) provides: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities."

9. The Miller court provided an example of a state statute that regulated insurance but did not substantially affect the risk pooling arrangement: "A state law requiring all insurance companies to pay their janitors twice the minimum wage would not 'regulate insurance,' even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangement undertaken by insurer and insured." Miller, 538 U.S. at 338.

10. Under Hawaii's external review statute, the Commissioner is required to issue an order that affirms, modifies, or reverses the internal determination of the insurer. HRS § 432E-8 (Supp. 2003) authorizes the Commissioner to enforce an order pursuant to Article 2 of chapter 431. Within Article 2 is HRS § 431:2-203(c) (Supp. 2003), which provides that if an insurance licensee "persistently, substantially violates . . . an order of the commissioner . . . the commissioner may . . . in whole or in part, suspend, place on probation, limit or refuse to renew the license or certificate of authority[.]" A license is required for selling, soliciting, or negotiating insurance in this state. HRS § 431:9A-103 (Supp. 2003). Therefore, if a managed care plan

does not submit to an external review, the Commissioner may restrict or terminate the ability of the insurer to conduct business in Hawai`i.

11. 29 U.S.C. § 1132 provides in relevant part:

> (a) Persons empowered to bring a civil action
>
> A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]

12. In Rush Prudential, the patient sued the HMO to compel compliance with the Illinois statute; the HMO, however, removed the case to federal court and argued that ERISA's civil enforcement provision preempted the Illinois regulatory scheme. Rush Prudential, 536 U.S. at 362.

13. The Court constrained its holding, however, with the following footnote:

> We do not mean to imply that States are free to create other forms of binding arbitration to provide de novo review of any terms of insurance contracts; as discussed above, our decision rests in part on our recognition that the disuniformity Congress hoped to avoid is not implicated by decisions that are so heavily imbued with expert medical judgments. Rather, we hold that the feature of § 4-10 that provides a different standard of review with respect to mixed eligibility decisions from what would be available in court is not enough to create a conflict that undermines congressional policy in favor of uniformity of remedies.

Rush Prudential, 536 U.S. at 386 n.17. The Court also stated that "any lingering doubt about the reasonableness of § 4-10 in affecting the application of § 1132(a) may be put to rest by recalling that regulating insurance tied to what is medically necessary is probably inseparable from enforcing the quintessentially state-law standards of reasonable medical care." Id. at 387.
As discussed in subsection c, infra, HRS § 432E-6 differs from § 4-10 in several crucial ways, such that HRS § 432E-6 is not protected by Rush Prudential.

14. A "cause of action" is:

> 1. A group of operative facts giving rise to one or more bases for suing; a factual situation that entitles one person to obtain a remedy in court from another person; CLAIM
>
> . . . .
>
> 2. A legal theory of a lawsuit . . . .

3. Loosely, a lawsuit . . . .

Black's Law Dictionary 214 (7th ed. 1999).

15. Indeed, Rush Prudential seems to anticipate Aetna Health, further evidence that the two cases are consistent. As the Court stated in Rush Prudential:

> Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the "reservation of the business of insurance to the States," Metropolitan Life, 471 U.S., at 744 n. 21, we have anticipated such a conflict, with the state insurance regulation losing out if it allows plan participants "to obtain remedies . . . that Congress rejected in ERISA," Pilot Life, supra, at 54.

Rush Prudential, 536 U.S. at 377 (alteration in original).

16. We pause to note that claimants such as Baldado who have relied upon HRS § 432E-6 in pursuing claims for medical coverage have six years from an HMO's denial of coverage in which to file an ERISA claim. See HRS § 657-1 (1993) (providing a six-year limitations period for "[a]ctions for the recovery of any debt founded upon any contract, obligation, or liability" and for "[p]ersonal actions of any nature whatsoever not specifically covered by the laws of the State"); Bd. of Regents of Univ. of State of N.Y. v. Tomanio, 446 U.S. 478, 483-84 (1980) (holding that where Congress does not establish a statute of limitations applicable to a federal cause of action, "a void which is commonplace in federal statutory law[,] . . . this Court has repeatedly 'borrowed' the state law of limitations governing an analogous cause of action"); Shofer v. Hack Co., 970 F.2d 1316, 1319 (4th Cir. 1992) ("ERISA does not expressly provide a limitation period for bringing a private action other than for claims of a breach of fiduciary duty. Therefore, for any claim that does not assert that Hack breached a fiduciary duty, the court must look to state law and apply an analogous limitation provision.") Miles v. New York State Teamsters Conference Pension & Ret. Fund Employee Pension Ben. Plan, 698 F.2d 593, 598 (2d Cir. 1983) ("As ERISA does not prescribe a limitations period for actions under § 1132, the controlling limitations period is that specified in the most nearly analogous state limitations statute.").

NO. 24801

IN THE SUPREME COURT OF THE
STATE OF HAWAII

HAWAII MANAGEMENT ALLIANCE ASSOCIATION, Appellant-Appellant, vs. THE INSURANCE COMMISSIONER and the DIVISION OF INSURANCE, of the DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAII; and KEVIN BALDADO, Appellees-Appellees.	) CIVIL NO. 01-1 -1 061)) APPEAL FROM THE) 1) DECISION AND ORDER AFFIRMING) COMMISSIONER'S FINAL ORDERS,) filed on December 5, 2001) 2) JUDGMENT,) filed on February 4,) 2002) FIRST CIRCUIT COURT) HONORABLE EDEN) ELIZABETH HIFO) Judge

NOTICE AND JUDGMENT ON APPEAL
CERTIFICATE OF SERVICE

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NO. 24801

IN THE SUPREME COURT OF THE
STATE OF HAWAII

HAWAII MANAGEMENT ALLIANCE ASSOCIATION, Appellant-Appellant, vs. THE INSURANCE COMMISSIONER and the DIVISION OF INSURANCE, of the DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAII; and KEVIN BALDADO, Appellees-Appellees.	) CIVIL NO. 01-1 -1 061)) APPEAL FROM THE) 1) DECISION AND ORDER AFFIRMING COMMISSIONER'S FINAL ORDERS,) filed on December 5, 2001) 2) JUDGMENT,) filed on February 4, 2002)) FIRST CIRCUIT COURT) HONORABLE EDEN ELIZABETH HIFO) Judge

NOTICE AND JUDGMENT ON APPEAL

TO: THE HONORABLE EDEN ELIZABETH HIFO OF THE CIRCUIT COURT OF THE FIRST CIRCUIT, STATE OF HAWAI'I

THE INSURANCE COMMISSIONER OF THE DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS, STATE OF HAWAI'I

PLEASE TAKE NOTICE the following Judgment on Appeal is entered this day by the Supreme Court of the State of Hawai`i:

Pursuant to the Opinion of the Supreme Court of the State of Hawai`i entered on November 18, 2004 and the Amended Opinion of the Supreme Court of the

State of Hawai'i entered on December 16, 2004, (1) the Insurance Commissioner's Order Granting Attorneys' Fees and Costs, entered on March 1, 2001; (2) the Insurance Commissioner's Order Denying Respondent's Motion for Reconsideration, entered on March 22, 2001; and (3) the First Circuit Court's Judgment, entered on February 4, 2002, are hereby vacated.

BY THE COURT: DEC 28 2004

/s E. M. Rimando
Clerk

APPROVED:

/s James E. Duffy, Jr.
(Justice/Judge)

{SEAL}
APPELLATE COURTS
SEAL
STATE OF HAWAI`I

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this date, I caused a true and correct copy of the foregoing to be served on the following by having said copy deposited in the United States mail, postage prepaid, addressed as follows:

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DATED: Honolulu, Hawai`i, December 17, 2004

s/ Dianne Winter Brookins

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15 U.S.C. § 1011. Declaration of policy

The Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

15 U.S.C. § 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation. The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation. No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act [15 USCS §§ 1 et seq.], and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 USCS §§ 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 USCS § 1109];

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 USCS § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provision of this title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c) or under subsection (i) or (l);

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 609(a)(2)(A) [29 USCS § 1169(a)(2)(A)]);

(8) by the Secretary, or by an employer or other person referred to in section 101(f)(1) [29 USCS § 1021(f)(1)], (A) to enjoin any act or practice which violates subsection (f) of section 101 [29 USCS § 1021(f)], or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title [subtitle] or the terms of

the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS § 1003(a)] and not exempt under section 4(b) [29 USCS § 1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application.

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2) (A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 USCS § 1003(a)], which is not exempt under section 4(b) [29 USCS § 1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State

agency as permitted under section 506 of this Act [29 USCS § 1136].

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5) (A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev.Stat.§§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)--

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle [29 USCS § § 1021 et seq., 1101 et seq.], and the preceding sections of this part [29 USCS § § 1131 et seq.] to the extent they govern matters which are governed by the provisions of such parts 1 and 4 [29 USCS § § 1021 et seq., 1101 et seq.], shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph [enacted Jan. 14, 1983]), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 [29 USCS § 1136] with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 [29 USCS § § 1021 et seq., 1101 et seq.] and the preceding sections of this part [29 USCS § 1131 et seq.].

§ 215 ILCS 125/4-10. Medical Necessity – Dispute Resolution – Independent Second Opinion

Sec. 4-10. Medical Necessity -- Dispute Resolution -- Independent Second Opinion. Each Health Maintenance Organization shall provide a mechanism for the timely review by a physician holding the same class of license as the primary care physician, who is unaffiliated with the

Health Maintenance Organization, jointly selected by the patient (or the patient's next of kin or legal representative if the patient is unable to act for himself), primary care physician and the Health Maintenance Organization in the event of a dispute between the primary care physician and the Health Maintenance Organization regarding the medical necessity of a covered service proposed by a primary care physician. In the event that the reviewing physician determines the covered service to be medically necessary, the Health Maintenance Organization shall provide the covered service. Future contractual or employment action by the Health Maintenance Organization regarding the primary care physician shall not be based solely on the physician's participation in this procedure.

HAWAII REVISED STATUTES

HRS §432E-1.4 Medical necessity.

(a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.

(b) A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

(1) For the purpose of treating a medical condition;

(2) The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

(3) Known to be effective in improving health outcomes; provided that:

(A) Effectiveness is determined first by scien-

tific evidence;

(B) If no scientific evidence exists, then by professional standards of care; and

(C) If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and

(4) Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

(c) When the treating licensed health care provider and the health plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan's medical director or physician designee.

(d) For the purposes of this section:

"Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

"Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

"Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness

has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

"Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

"Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

"Physician designee" means a physician or other health care practitioner designated to assist in the decision making process who has training and credentials at least equal to the treating licensed health care provider.

"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained

either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

(1) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(2) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);

(3) Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;

(4) Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;

(5) Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes for Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

(6) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

"Treat" means to prevent, diagnose, detect, provide medical care, or palliate.

"Treating licensed health care provider" means a li-

censed health care provider who has personally evaluated the patient.

HRS §432E-5 Complaints and appeals procedure for enrollees

(a) A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals. The procedure shall provide for expedited appeals under section 432E-6.5. The definition of medical necessity in section 432E-1 shall apply in a managed care plan's complaints and appeals procedures.

(b) The managed care plan shall at all times make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in a language other than English upon request.

(c) A managed care plan shall decide any expedited appeal as soon as possible after receipt of the complaint, taking into account the medical exigencies of the case, but not later than seventy-two hours after receipt of the request for expedited appeal.

(d) A managed care plan shall send notice of its final internal determination within sixty days of the submission of the complaint to the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the commissioner. The notice shall include the following information regarding the enrollee's rights and procedures:

(1) The enrollee's right to request an external review;

(2) The sixty-day deadline for requesting the external review;

(3) Instructions on how to request an external review; and

(4) Where to submit the request for an external review.

HRS § 432E-6 External review procedure

(a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner composed of a representative from a managed care plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for external review to the commissioner within sixty days from the date of the final internal determination by the managed care plan;

(2) The commissioner may retain:

(A) Without regard to chapter 76, an independent medical expert trained in the field of medicine most appropriately related to the matter under review. Presentation of evidence for this purpose shall be exempt from section 91-9(g); and

(B) The services of an independent review organization from an approved list maintained by the commissioner;

(3) Within seven days after receipt of the request for external review, a managed care plan or its designee utilization review organization shall provide to the commissioner or the assigned independent review organization:

(A) Any documents or information used in making the final internal determination including the enrollee's medical records;

(B) Any documentation or written information submitted to the managed care plan in support of the enrollee's initial complaint; and

(C) A list of the names, addresses, and telephone numbers of each licensed health care pro-

vider who cared for the enrollee and who may have medical records relevant to the external review;

provided that where an expedited appeal is involved, the managed care plan or its designee utilization review organization shall provide the documents and information within forty-eight hours of receipt of the request for external review.

Failure by the managed care plan or its designee utilization review organization to provide the documents and information within the prescribed time periods shall not delay the conduct of the external review. Where the plan or its designee utilization review organization fails to provide the documents and information within the prescribed time periods, the commissioner may issue a decision to reverse the final internal determination, in whole or part, and shall promptly notify the independent review organization, the enrollee, the enrollee's appointed representative, if applicable, the enrollee's treating provider, and the managed care plan of the decision;

(4) Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the external review panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel;

(5) The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that:

(A) The hearing shall be held no later than sixty days from the date of the request for the hearing; and

(B) An external review conducted as an expedited appeal shall be determined no later than seventy-two hours after receipt of the request for external review;

(6) After considering the enrollee's complaint, the managed care plan's response, and any affidavits filed by

the parties, the commissioner may dismiss the request for external review if it is determined that the request is frivolous or without merit; and

(7) The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably. The review panel and the commissioner or the commissioner's designee shall consider:

(A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;

(B) Whether the medical director properly applied the medical necessity criteria in section 432E-1.4 in making the final internal determination;

(C) All relevant medical records;

(D) The clinical standards of the plan;

(E) The information provided;

(F) The attending physician's recommendations; and

(G) Generally accepted practice guidelines.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

(c) No person shall serve on the review panel or in the independent review organization who, through a familial relationship within the second degree of consanguinity or affinity, or for other reasons, has a direct and substantial professional, financial, or personal interest in:

(1) The plan involved in the complaint, including an officer, director, or employee of the plan; or

(2) The treatment of the enrollee, including but not limited to the developer or manufacturer of the principal

drug, device, procedure, or other therapy at issue.

(d) Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

(e) An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs incurred in connection with the external review under this section, unless the commissioner in an administrative proceeding determines that the appeal was unreasonable, fraudulent, excessive, or frivolous.

(f) Disclosure of an enrollee's protected health information shall be limited to disclosure for purposes relating to the external review.

HRS § 432E-13 Annual report

The commissioner shall submit annually to the legislature a report that shall contain the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed. The identities of the plan and the enrollee shall be protected from disclosure in the report.

HAWAII 19TH STATE LEGISLATURE

ACT 178

SENATE BILL NO. 2297

SYNOPSIS: A BILL FOR AN ACT RELATING TO HEALTH.

NOTICE: [A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A] [D> Text within these symbols is deleted <D]

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Health care is an evolving industry. New technologies, procedures, and pharmaceuticals have con-

tributed to better health care for the consumer. However, new advances in medicine are not cheap. One problem with health care has been rising costs. One way health plans attempt to deal with rising costs of medicine is through managed care. Major features of a managed care system are prevention, use of "gatekeepers", and capitation.

Managed care has evolved, and Hawaii has been fortunate not to experience the questionable practices of certain entities engaging in managed care. Nevertheless, legitimate concerns provide the legislature with sufficient reason to protect the citizens of this State from certain practices of managed care.

The purpose of this Act is to create a new chapter to afford patients of managed care systems certain rights and protections.

SECTION 2. Title 24, Hawaii Revised Statutes, is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

HAWAII PATIENT BILL OF RIGHTS AND RESPONSIBILITIES ACT

Section -1 Definitions. As used in this chapter, unless the context otherwise requires:

"Appeal" means a request from an enrollee to change a previous decision made by the managed care plan.

"Commissioner" means the insurance commissioner.

"Complaint" means an expression of dissatisfaction, either oral or written.

"Emergency services" means services provided to an enrollee when the enrollee has symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the enrollee's health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death.

"Enrollee" means a person who enters into a contractual relationship or who is provided with health care services or benefits through a managed care plan.

"Health maintenance organization" means a health maintenance organization as defined in section 432D-1.

"Managed care plan" means any plan, regardless of form, offered or administered by any person or entity, including but not limited to an insurer governed by chapter 431, a mutual benefit society governed by chapter 432, a health maintenance organization governed by chapter 432D, a preferred provider organization, a point of service organization, a health insurance issuer, a fiscal intermediary, a payor, a prepaid health care plan, and any other mixed model, that provides for the financing or delivery of health care services or benefits to enrollees through:

(1) Arrangements with selected providers or provider networks to furnish health care services or benefits; and

(2) Financial incentives for enrollees to use participating providers and procedures provided by a plan;

provided, that for the purposes of this chapter, an employee benefit plan shall not be deemed a managed care plan with respect to any provision of this chapter or to any requirement or rule imposed or permitted by this chapter which is superseded or preempted by federal law.

"Participating provider" means a licensed or certified provider of health care services or benefits, including mental health services and health care supplies, that has entered into an agreement with a managed care plan to provide those services or supplies to enrollees.

Section -2 Conflict with other laws. If there is a conflict with any other law, this chapter shall prevail to the extent that this chapter offers greater protection or rights to the enrollee.

Section -3 Access to services. A managed care plan shall demonstrate to the commissioner upon request that its plan:

(1) Makes benefits available and accessible to each enrollee electing the managed care plan in the defined

service area with reasonable promptness and in a manner which promotes continuity in the provision of health care services;

(2) Provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay;

(3) When medically necessary, provides health care services twenty-four hours a day, seven days a week;

(4) Provides a reasonable choice of qualified providers of women's health services such as gynecologists, obstetricians, certified nurse-midwives, and advanced practice nurses to provide preventive and routine women's health care services; and

(5) Provides payment or reimbursement for emergency services.

Section -4 Enrollee participation in treatment decisions. (a) An enrollee shall have the right to be informed fully prior to making any decision about any treatment, benefit, or nontreatment.

(b) In order to inform enrollees fully, the provider shall:

(1) Discuss all treatment options with an enrollee and include the option of no treatment at all;

(2) Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan; and

(3) Discuss all risks, benefits, and consequences to treatment and nontreatment.

(c) The provider shall discuss with the enrollee and the enrollee's immediate family both living wills and durable powers of attorney in relation to medical treatment, as provided for in chapter 327D and section 551D-2.5.

(d) A managed care plan shall be prohibited from imposing any type of prohibition, disincentive, penalty, or other negative treatment upon a provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not provided by the managed care plan.

Section -5 Complaints and appeals procedure for enrollees. (a) A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals.

(b) The managed care plan at all times shall make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in languages other than English upon request.

Section -6 Appeals to the commissioner. (a) After exhausting all internal complaint and appeal procedures available, an enrollee may appeal an adverse decision of a managed care plan to a three member review panel appointed by the commissioner composed of a representative from a health plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for review to the commissioner within thirty days from the date of the final determination by the managed care plan.

(2) Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91.

(3) After considering the enrollee's complaint, the plan's response, and any affidavits filed by the parties, the commissioner may dismiss the appeal if it is determined that the appeal is frivolous or without merit.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

(c) The commissioner may adopt rules pursuant to chap-

ter 91 to carry out the purposes of this section.

Section -7 Information to enrollees. (a) The managed care plan shall provide to its enrollees upon enrollment and thereafter upon request the following information:

(1) A list of participating providers which shall indicate their specialty and whether board certification has been attained;

(2) A complete description of benefits, services, and copayments;

(3) A statement on enrollee's rights, responsibilities, and obligations;

(4) An explanation of the referral process, if any;

(5) Where services or benefits may be obtained;

(6) A statement regarding informed consent;

(7) Information on complaints and appeals procedures; and

(8) The telephone number of the insurance division and the office of consumer complaints.

This information shall be provided to prospective enrollees upon request.

(b) Every managed care plan shall provide to its enrollees notice of any material change in the operation of the organization initiated by the plan that will affect them directly within thirty days of the material change.

(c) For purposes of this section "material change" means a change in participating provider agreements, services, or benefits.

Section -8 Enforcement. All remedies, penalties, and proceedings in articles 2 and 13 of chapter 431 made applicable hereby to managed care plans shall be invoked and enforced solely and exclusively by the commissioner.

Section -9 Utilization review. (a) Every managed care plan shall establish procedures for continuous review of quality of care, performance of providers, utilization of health services, facilities, and costs.

(b) Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause

of action for damages shall arise against, any person who participates in quality of care or utilization reviews by peer review committees for any act performed during the reviews if the person acts without malice, makes a reasonable effort to obtain the facts, and believes that the action taken is warranted by the facts.

(c) No peer review committee under this section shall be subject to discovery, and no person in attendance at the reviews shall be required to testify as to what transpired at the reviews. The utilization review requirements and administrative treatment guidelines of the health maintenance organization shall not fall below the appropriate standard of care and shall not impinge upon the independent medical judgment of the treating health care provider.

(d) Nothing in this section shall be construed to prevent a health maintenance organization from conducting a utilization review and quality assurance program.

Section -10 Managed care plan performance measurement and data reporting standards. (a) It is the policy of this State that all managed care plans shall adopt and comply with nationally developed and promulgated standards for measuring quality, outcomes, access, satisfaction, and utilization of services. Every contract between a managed care plan and a participating provider of health care services shall require the participating provider to comply with the managed care plan's requests for any information necessary for the managed care plan to comply with the requirements of this chapter. The standard to be applied is the Health Employer Data and Information Set (HEDIS) 3.0 data set, as amended from time to time. The State shall require that:

(1) Consumers, providers, managed care plans, purchasers, and regulators shall be equitably represented in the development of standards; and

(2) Standards shall result in measurement and reporting that is purposeful, valid and scientifically based, applied in a consistent and comparable manner, efficient and cost effective, and designed to minimize redundancy

and duplication of effort.

(b) All managed care plans, no less than annually, shall report to the commissioner comparable information on performance, including measures of quality, outcomes, access, satisfaction, and utilization of services; provided that:

(1) Reporting shall be based upon a core data and information set that builds upon nationally recognized performance measurement systems. The core data and information set shall include standardized measures of:

(A) Effectiveness and appropriateness of care (the impact of care delivered to managed care plan enrollees, including results of the plan for childhood immunizations, cholesterol screening, mammography screening, cervical cancer screening, prenatal visits in the first trimester of pregnancy, and diabetic retinal examinations);

(B) Access and availability of care (the extent to which plan enrollees have access to the health care providers they need or desire to see, and receive appropriate services in a timely manner, without inappropriate barriers or inconvenience);

(C) Satisfaction with the experience of care (the results of the most recent enrollee satisfaction survey using standardized survey design and methods);

(D) Managed care plan stability (attributes of a managed care plan which affect its ability to deliver high-quality care and service on a sustained basis);

(E) Use of services (rates of service use per 1,000 enrollees as well as percentages of enrollees who receive specified services);

(F) Cost of care (expenditures per enrollee per month, premium rates for selected membership categories, and rates of increases); and

(G) Managed care plan descriptive information (the plan name, location of headquarters, and number of years the plan has been in business; the model type of the plan; the counties in which the plan operates; the total number of participating physicians per 1,000 enrollees and the

number of primary care physicians per 1,000 enrollees; the number of participating hospitals per 10,000 enrollees; the percentage of participating physicians who are board certified; and a list of wellness and health care education programs offered by the plan);

(2) Information shall be uniformly reported by managed care plans in a standardized format, as determined by rule;

(3) Information supplied by managed care plans shall be subject to independent audit by the appropriate regulatory agency or its designee to verify accuracy and protect against misrepresentation;

(4) Information reported by managed care plans shall be adjusted, based on standardized methods, to control for the effects of differences in health risk, severity of illness, or mix of services;

(5) A managed care plan shall ensure confidentiality of records and shall not disclose individually identifiable data or information pertaining to the diagnosis, treatment, or health of any enrollee, except as provided under law; and

(6) A managed care plan shall disclose to its enrollees the quality and satisfaction assessments used, including the current results of the assessments."

SECTION 3. Section 432:1-102, Hawaii Revised Statutes, is amended to read as follows:

"Section 432:1-102 Applicability of other laws [D> to nonprofit medical indemnity or hospital service associations: health care coverage for senior citizens <D] . [A> (A) <A] Part III of article 10A of [D> the insurance code <D] [A> CHAPTER 431 <A] shall apply to nonprofit medical indemnity or hospital service associations. Such associations shall be exempt from the provisions of part I of article 10A; provided that such exemption is in compliance with applicable federal statute and regulations.

[A> (B) ARTICLE 2 AND ARTICLE 13 OF CHAPTER 431, AND THE POWERS THERE GRANTED TO THE COMMISSIONER, SHALL APPLY TO MANAGED

CARE PLANS, HEALTH MAINTENANCE ORGANIZATIONS, OR MEDICAL INDEMNITY OR HOSPITAL SERVICE ASSOCIATIONS, WHICH ARE OWNED OR CONTROLLED BY MUTUAL BENEFIT SOCIETIES, SO LONG AS SUCH APPLICATION IN ANY PARTICULAR CASE IS IN COMPLIANCE WITH AND IS NOT PREEMPTED BY APPLICABLE FEDERAL STATUTES AND REGULATIONS. <A] "

SECTION 4. Section 432D-19, Hawaii Revised Statutes, is amended to read as follows:

"432D-19 Statutory construction and relationship to other laws. (a) Except as [A> PROVIDED IN SUBSECTION (D) AND <A] otherwise provided in this chapter, the insurance laws and hospital or medical service corporation laws shall not apply to the activities authorized and regulated under this chapter of any any health maintenance organization granted a certificate of authority under this chapter. This chapter shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance laws or the hospital or medical service corporation laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization granted a certificate of authority under this chapter shall not be deemed to be practicing medicine and shall be exempt from the provision of chapter 453 relating to the practice of medicine or chapter 460 relating to the practice of osteopathic medicine.

[A> (D) ARTICLE 2 AND ARTICLE 13 OF CHAPTER 431, AND THE POWER THERE GRANTED TO THE COMMISSIONER, SHALL APPLY TO HEALTH MAINTENANCE ORGANIZATIONS, SO LONG AS SUCH AP-

PLICATION IN ANY PARTICULAR CASE IS IN COMPLIANCE WITH AND IS NOT PREEMPTED BY APPLICABLE FEDERAL STATUTES AND REGULATIONS. <A] "

SECTION 5. (a) The insurance commissioner shall convene a task force comprised of various members from the public and private sector to review various laws which provide protection of patient rights and responsibilities in regards to health care, especially managed care.

(b) The task force shall review this Act and determine whether consumer rights are fully protected under this Act and whether any further action is needed to ensure such protection.

(c) The task force shall be comprised of interested parties with the total membership of the task between twelve and twenty members. The insurance commissioner or the commissioner's designated representative, shall be a member and serve as the chair of the task force and appoint it remaining members. At least one representative from each of the following shall be appointed as a member; members of other groups may also be appointed:

(1) The department of health;

(2) The department of labor and industrial relations, disability compensation division;

(3) A health insurance company that provides accident and sickness policies under chapter 431, article 10A, Hawaii Revised Statutes;

(4) A mutual benefit society that provides health insurance under chapter 432, Hawaii Revised Statutes;

(5) A health maintenance organization that holds a certificate of authority under chapter 432D, Hawaii Revised Statutes;

(6) The American Association of Retired Persons;

(7) The Hawaii Coalition for Health;

(8) The Hawai`i Business Health Coalition;

(9) The Legal Aid Society of Hawaii;

(10) The Hawaii Medical Association;

(11) An organization that represents nurses; and

(12) A hospital or an organization that represents hospitals.

(d) The task force shall submit its preliminary findings and recommendations to the legislature not later than twenty days prior to the convening of the 1999 regular session.

(e) The task force shall continue until terminated by the insurance commissioner.

SECTION 6. If any provision of this Act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 7. Statutory material to be repealed is bracketed. New statutory material is underscored.

SECTION 8. This act shall take effect upon its approval.

HISTORY:

Approved by the Governor July 15, 1998.

Act 137, 1999 Haw. Sess. L.:

HAWAII THE 20TH STATE LEGISLATURE

ACT 137

SENATE BILL NO. 1452

SYNOPSIS: A BILL FOR AN ACT RELATING TO HEALTH.

NOTICE: [A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A] [D> Text within these symbols is deleted <D]

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

[*1] **SECTION 1.** Act 178, Session Laws of Hawaii 1998, enacted the Hawaii Patient Bill of Rights and Responsibilities Act to regulate managed care. Act 178 also required the insurance commissioner to convene a task

force to review various laws providing protection of patient rights and responsibilities with regard to health care, especially managed care. This Act contains the statutory revisions recommended by the task force to ensure the protection of consumer rights.

The purpose of this Act is to strengthen the protection of the consumer rights of patients receiving health care under managed care plans and from health maintenance organizations.

[*2] **SECTION 2.** Chapter 432E, Hawaii Revised Statutes, is amended by adding three new sections to be appropriately designated and to read as follows:

" [A> SECTION 432E -A ANNUAL REPORT. THE COMMISSIONER SHALL SUBMIT ANNUALLY TO THE LEGISLATURE A REPORT THAT SHALL CONTAIN THE NUMBER OF EXTERNAL REVIEW HEARING CASES REVIEWED, THE TYPE OF CASES REVIEWED, A SUMMARY OF THE NATURE OF THE CASES REVIEWED, AND THE DISPOSITION OF THE CASES REVIEWED. THE IDENTITIES OF THE PLAN AND THE ENROLLEE SHALL BE PROTECTED FROM DISCLOSURE IN THE REPORT. <A]

[A> SECTION 432E -B ACCREDITATION OF MANAGED CARE PLANS. <A]

[A> (A) BEGINNING JANUARY 1, 1999, THE COMMISSIONER SHALL CONTRACT WITH ONE OR MORE CERTIFIED VENDORS OF THE CONSUMER ASSESSMENT HEALTH PLAN SURVEY TO CONDUCT A SURVEY OF ALL MANAGED CARE PLANS ACTIVELY OFFERING MANAGED CARE PLANS IN THIS STATE TO PROVIDE MANAGED CARE PLANS AN OPPORTUNITY TO LEARN WHETHER ANY DEFICIENCIES EXIST OR ANY IMPROVEMENTS ARE REQUIRED; PROVIDED THAT THE INFORMATION COLLECTED SHALL BE KEPT CONFIDENTIAL IN THE FIRST YEAR, AND THEREAFTER SHALL BE AVAILABLE TO THE PUBLIC. <A]

[A> (B) THE COMMISSIONER SHALL CONDUCT A

PROGRAM THAT PROMOTES PUBLIC AWARENESS AND EDUCATION ABOUT MANAGED CARE PLANS SO THAT CONSUMERS MAY MAKE BETTER OR MORE INFORMED CHOICES WHEN SELECTING A MANAGED CARE PLAN. <A]

[A> (C) BEGINNING ~~JANUARY~~ 1, 2000, UNACCREDITED PLANS SHALL SUBMIT A PLAN TO THE COMMISSIONER TO ACHIEVE NATIONAL ACCREDITATION STATUS WITHIN FIVE YEARS. AFTER THE FIRST YEAR OF THE FIVE-YEAR PLAN, EACH UNACCREDITED PLAN SHALL ALSO SUBMIT AN ANNUAL PROGRESS REPORT TO THE COMMISSIONER ON THE STATUS OF GAINING NATIONAL ACCREDITATION. THE COMMISSIONER SHALL DETERMINE WHICH NATIONAL ACCREDITATION ORGANIZATION IS APPROPRIATE FOR EACH TYPE OF PLAN. <A]

[A> (D) EVERY MUTUAL BENEFIT SOCIETY, EVERY HEALTH MAINTENANCE ORGANIZATION, AND EVERY OTHER ENTITY OFFERING OR PROVIDING HEALTH BENEFITS OR SERVICES UNDER THE REGULATION OF THE COMMISSIONER, EXCEPT AN INSURER LICENSED TO OFFER HEALTH INSURANCE UNDER ARTICLE 10A OF CHAPTER 431, SHALL DEPOSIT WITH THE COMMISSIONER A FEE TO PROVIDE FOR THE ACTUAL COSTS OF THE SURVEY AND EDUCATIONAL PROGRAM TO BE DETERMINED BY THE COMMISSIONER ON JULY 1 OF EACH YEAR, TO BE CREDITED TO THE INSURANCE REGULATION FUND. IN ADDITION, EVERY MUTUAL BENEFIT SOCIETY, EVERY HEALTH MAINTENANCE ORGANIZATION, AND EVERY OTHER ENTITY OFFERING OR PROVIDING HEALTH BENEFITS OR SERVICES UNDER THE REGULATION OF THE COMMISSIONER, EXCEPT AN INSURER LICENSED TO OFFER HEALTH INSURANCE UNDER ARTICLE 10A OF CHAPTER 431, SHALL PAY TO THE COMMISSIONER AT A TIME TO BE DETERMINED BY THE COMMISSIONER, A ONE-TIME ASSESS-

MENT IN AN AMOUNT TO BE DETERMINED BY THE COMMISSIONER, TO BE CREDITED TO THE INSURANCE REGULATION FUND. <A]

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[*4x1] **SECTION 4.1**. Section 432E-5, Hawaii Revised Statutes, is amended to read as follows:

"Section 432E-5 Complaints and appeals procedure for enrollees.

(a) A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals.

(b) The managed care plan at all times shall make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in languages other than English upon request.

[A> (C) A MANAGED CARE PLAN SHALL SEND NOTICE OF ITS FINAL INTERNAL DETERMINATION TO THE ENROLLEE, THE ENROLLEE'S APPOINTED REPRESENTATIVE, IF APPLICABLE, AND THE COMMISSIONER. THE NOTICE SHALL INCLUDE INFORMATION REGARDING THE ENROLLEE'S RIGHTS AND PROCEDURES UNDER SECTION 432E-6. <A] "

[*5] **SECTION 5**. Section 432E-6, Hawaii Revised Statutes, is amended to read as follows:

"Section 432E-6 Appeals to the commissioner.

(a) After exhausting all internal complaint and appeal procedures available, an enrollee [A> , OR THE ENROLLEE'S TREATING PROVIDER OR APPOINTED REPRESENTATIVE, <A] may appeal an adverse decision of a managed care plan to a [D> three member <D] [A> THREE-MEMBER <A] review panel appointed by the commissioner composed of a representative from a health plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for review to the commissioner within thirty days from the date of the final determination by the managed care plan [D> . <D] [A> ; <A]

(2) Upon receipt of the request and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91. [A> IF THE AMOUNT IN CONTROVERSY IS LESS THAN $ 500, THE COMMISSIONER MAY CONDUCT A REVIEW HEARING WITHOUT APPOINTING A REVIEW PANEL; <A]

[A> (3) THE REVIEW HEARING SHALL BE CONDUCTED AS SOON AS PRACTICABLE, TAKING INTO CONSIDERATION THE MEDICAL EXIGENCIES OF THE CASE; PROVIDED THAT THE HEARING SHALL BE HELD NO LATER THAN SIXTY DAYS FROM THE DATE OF THE REQUEST FOR THE HEARING; <A]

[A> (4) THE COMMISSIONER MAY RETAIN, WITHOUT REGARD TO CHAPTERS 76 AND 77, AN INDEPENDENT MEDICAL EXPERT TRAINED IN THE FIELD OF MEDICINE MOST APPROPRIATELY RELATED TO THE MATTER UNDER REVIEW. PRESENTATION OF EVIDENCE FOR THIS PURPOSE SHALL BE EXEMPT FROM SECTION 91-9(G); <A]

[D> (3) <D] [A> (5) <A] After considering the enrollee's complaint, the plan's response, and any affidavits filed by the parties, the commissioner may dismiss the appeal if it is determined that the appeal is frivolous or without merit [D> . <D] [A> ; AND <A]

[A> (6) THE REVIEW PANEL SHALL REVIEW EVERY ADVERSE DETERMINATION TO DETERMINE WHETHER OR NOT THE PLAN INVOLVED ACTED REASONABLY AND WITH SOUND MEDICAL JUDGMENT. THE REVIEW PANEL SHALL CONSIDER THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED, THE ATTENDING PHYSICIAN'S RECOMMENDATIONS, AND GENERALLY ACCEPTED PRACTICE GUIDELINES. <A] The commissioner, upon a majority vote of the panel, shall issue an order affirm-

ing, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

[D> (c) The commissioner may adopt rules pursuant to chapter 91 to carry out the purposes of this section. <D]

[A> (C) MEMBERS OF THE REVIEW PANEL SHALL BE GRANTED IMMUNITY FROM LIABILITY AND DAMAGES RELATING TO THEIR DUTIES UNDER THIS SECTION. <A]

[A> (D) AN ENROLLEE MAY BE ALLOWED, AT THE COMMISSIONER'S DISCRETION, AN AWARD OF A REASONABLE SUM FOR ATTORNEY'S FEES AND REASONABLE COSTS OF SUIT IN AN ACTION BROUGHT AGAINST THE MANAGED CARE PLAN. <A] "

* * * * *

[*11] **SECTION 11.** The patient rights and responsibilities task force shall develop proposed legislation addressing issues within the scope of the task force's responsibilities under Act 178, Session Laws of Hawaii 1998, left unresolved by this Act. The proposed legislation shall be submitted to the legislature no later than twenty days before the convening of the regular session of 2000.

* * * * *

HISTORY:

Approved by the Governor June 25, 1999.

Act 250, 2000 Haw. Sess. L.:

HAWAII THE 20TH STATE LEGISLATURE

SENATE BILL NO. 2655

SYNOPSIS: A BILL FOR AN ACT RELATING TO HEALTH.

NOTICE: [A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A] [D> Text within these symbols is deleted <D]

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

PART I

[*1] **SECTION 1**. The legislature, in section 12 of Act 137, Session Laws of Hawaii 1999, directed the Hawaii patient rights and responsibilities task force to develop proposed legislation addressing issues within the scope of the task force's responsibilities under Act 178, Session Laws of Hawaii 1998. This part is submitted in response to the legislature's mandate.

* * * * *

[*3] **SECTION 3**. Section 432E-5, Hawaii Revised Statutes, is amended to read as follows:

"Section 432E-5 Complaints and appeals procedure for enrollees. (a) A managed care plan with enrollees in this State shall establish and maintain a procedure to provide for the resolution of an enrollee's complaints and appeals. [A> THE PROCEDURE SHALL PROVIDE FOR EXPEDITED APPEALS UNDER SECTION 432E- . THE DEFINITION OF MEDICAL NECESSITY IN SECTION 432E- SHALL APPLY IN A MANAGED CARE PLAN'S COMPLAINTS AND APPEALS PROCEDURES. <A]

(b) The managed care plan [A> SHALL <A] at all times [D> shall <D] make available its complaints and appeals procedures. The complaints and appeals procedures shall be reasonably understandable to the average layperson and shall be provided in [D> languages <D] [A> A LANGUAGE <A] other than English upon request.

[A> (C) A MANAGED CARE PLAN SHALL DECIDE ANY EXPEDITED APPEAL AS SOON AS POSSIBLE AFTER RECEIPT OF THE COMPLAINT, TAKING INTO ACCOUNT THE MEDICAL EXIGENCIES OF THE CASE, BUT NOT LATER THAN SEVENTY-TWO HOURS AFTER RECEIPT OF THE REQUEST FOR EXPEDITED APPEAL. <A]

[D> (c) <D] [A> (D) <A] A managed care plan shall send notice of its final internal determination [A> WITHIN FORTY-FIVE DAYS OF THE SUBMISSION OF THE COMPLAINT <A] to the enrollee, the enrollee's appointed representative, if applicable, [A> THE ENROLLEE'S TREATING PROVIDER, <A] and the commissioner. The notice shall include [A> THE FOLLOWING <A] information regarding the enrollee's rights and procedures [D> under section 432E-6. <D] [A> : <A]

[A> (1) THE ENROLLEE'S RIGHT TO REQUEST AN EXTERNAL REVIEW; <A]

[A> (2) THE SIXTY-DAY DEADLINE FOR REQUESTING THE EXTERNAL REVIEW; <A]

[A> (3) INSTRUCTIONS ON HOW TO REQUEST AN EXTERNAL REVIEW; AND <A]

[A> (4) WHERE TO SUBMIT THE REQUEST FOR AN EXTERNAL REVIEW. <A] "

[*4] **SECTION 4**. Section 432E-6, Hawaii Revised Statutes, is amended to read as follows:

"Section 432E-6 [D> Appeals to the commissioner. <D] [A> EXTERNAL REVIEW PROCEDURE. <A] (a) After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may [D> appeal an adverse decision <D] [A> FILE A REQUEST FOR EXTERNAL REVIEW <A] of a managed care [D> plan <D] [A> PLAN'S FINAL INTERNAL DETERMINATION <A] to a three-member review panel appointed by the commissioner composed of a representative from a [D> health <D] [A> MANAGED CARE <A] plan not involved in the complaint, a provider licensed to practice and practicing medicine in Hawaii not involved in the complaint, and the commissioner or the commissioner's designee in the following manner:

(1) The enrollee shall submit a request for [A> EXTERNAL <A] review to the commissioner within [D> thirty <D] [A> SIXTY <A] days from the date of the final [A> INTERNAL <A] determination by the managed care

plan;

[A> (2) THE COMMISSIONER MAY RETAIN: <A]

[A> (A) WITHOUT REGARD TO CHAPTERS 76 AND 77, AN INDEPENDENT MEDICAL EXPERT TRAINED IN THE FIELD OF MEDICINE MOST APPROPRIATELY RELATED TO THE MATTER UNDER REVIEW. PRESENTATION OF EVIDENCE FOR THIS PURPOSE SHALL BE EXEMPT FROM SECTION 91-9(G); AND <A]

[A> (B) THE SERVICES OF AN INDEPENDENT REVIEW ORGANIZATION FROM AN APPROVED LIST MAINTAINED BY THE COMMISSIONER; <A]

[A> (3) WITHIN SEVEN DAYS AFTER RECEIPT OF THE REQUEST FOR EXTERNAL REVIEW, A MANAGED CARE PLAN OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION SHALL PROVIDE TO THE COMMISSIONER OR THE ASSIGNED INDEPENDENT REVIEW ORGANIZATION: <A]

[A> (A) ANY DOCUMENTS OR INFORMATION USED IN MAKING THE FINAL INTERNAL DETERMINATION INCLUDING THE ENROLLEE'S MEDICAL RECORDS; <A]

[A> (B) ANY DOCUMENTATION OR WRITTEN INFORMATION SUBMITTED TO THE MANAGED CARE PLAN IN SUPPORT OF THE ENROLLEE'S INITIAL COMPLAINT; AND <A]

[A> (C) A LIST OF THE NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF EACH LICENSED HEALTH CARE PROVIDER WHO CARED FOR THE ENROLLEE AND WHO MAY HAVE MEDICAL RECORDS RELEVANT TO THE EXTERNAL REVIEW; <A]

[A> PROVIDED THAT WHERE AN EXPEDITED REVIEW IS INVOLVED, THE MANAGED CARE PLAN OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION SHALL PROVIDE THE DOCUMENTS AND INFORMATION WITHIN FORTY-EIGHT HOURS OF RECEIPT OF THE REQUEST FOR EXTERNAL REVIEW. <A]

[A> FAILURE BY THE MANAGED CARE PLAN OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION TO PROVIDE THE DOCUMENTS AND INFORMATION WITHIN THE PRESCRIBED TIME PERIODS SHALL NOT DELAY THE CONDUCT OF THE EXTERNAL REVIEW. WHERE THE PLAN OR ITS DESIGNEE UTILIZATION REVIEW ORGANIZATION FAILS TO PROVIDE THE DOCUMENTS AND INFORMATION WITHIN THE PRESCRIBED TIME PERIODS, THE COMMISSIONER MAY ISSUE A DECISION TO REVERSE THE FINAL INTERNAL DETERMINATION, IN WHOLE OR PART, AND SHALL PROMPTLY NOTIFY THE INDEPENDENT REVIEW ORGANIZATION, THE ENROLLEE, THE ENROLLEE'S APPOINTED REPRESENTATIVE, IF APPLICABLE, THE ENROLLEE'S TREATING PROVIDER, AND THE MANAGED CARE PLAN OF THE DECISION; <A]

[D> (2) <D] [A> (4) <A] Upon receipt of the request [A> FOR EXTERNAL REVIEW <A] and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $ 500, the commissioner may conduct a review hearing without appointing a review panel;

[D> (3) <D] [A> (5) <A] The review hearing shall be conducted as soon as practicable, taking into consideration the medical exigencies of the case; provided that [D> the <D] [A> : <A]

[A> (A) THE <A] hearing shall be held no later than sixty days from the date of the request for the hearing; [A> AND <A]

[A> (B) AN EXTERNAL REVIEW CONDUCTED AS AN EXPEDITED APPEAL SHALL BE DETERMINED NO LATER THAN SEVENTY-TWO HOURS AFTER RECEIPT OF THE REQUEST FOR EXTERNAL REVIEW; <A]

[D> (4) The commissioner may retain, ~~without~~ regard to chapters 76 and 77, an independent medical expert trained in the field of medicine most appropriately re-

lated to the matter under review. Presentation of evidence for this purpose shall be exempt from section 91-9(g); <D]

[D> (5) <D] [A> (6) <A] After considering the enrollee's complaint, the [A> MANAGED CARE <A] plan's response, and any affidavits filed by the parties, the commissioner may dismiss the [D> appeal <D] [A> REQUEST FOR EXTERNAL REVIEW <A] if it is determined that the [D> appeal <D] [A> REQUEST <A] is frivolous or without merit; and

[D> (6) <D] [A> (7) <A] The review panel shall review every [D> adverse <D] [A> FINAL INTERNAL <A] determination to determine whether [D> or not <D] the [A> MANAGED CARE <A] plan involved acted reasonably [D> and with sound medical judgment <D] . The review panel [A> AND THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE <A] shall consider [D> the <D] [A> : <A]

[A> (A) THE TERMS OF THE AGREEMENT OF THE ENROLLEE'S INSURANCE POLICY, EVIDENCE OF COVERAGE, OR SIMILAR DOCUMENT; <A]

[A> (B) WHETHER THE MEDICAL DIRECTOR PROPERLY APPLIED THE MEDICAL NECESSITY CRITERIA IN SECTION 432E - IN MAKING THE FINAL INTERNAL DETERMINATION; <A]

[A> (C) ALL RELEVANT MEDICAL RECORDS; <A]

[A> (D) THE <A] clinical standards of the plan [D> , the <D] [A> ; <A]

[A> (E) THE <A] information provided [D> , the <D] [A> ; <A]

[A> (F) THE <A] attending physician's recommendations [D> , <D] [A> ; <A] and

[A> (G) <A] [D> generally <D] [A> GENERALLY <A] accepted practice guidelines.

The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision within thirty days of the hearing.

(b) The procedure set forth in this section shall not

apply to claims or allegations of health provider malpractice, professional negligence, or other professional fault against participating providers.

[A> (C) NO PERSON SHALL SERVE ON THE REVIEW PANEL OR IN THE INDEPENDENT REVIEW ORGANIZATION WHO, THROUGH A FAMILIAL RELATIONSHIP WITHIN THE SECOND DEGREE OF CONSANGUINITY OR AFFINITY, OR FOR OTHER REASONS, HAS A DIRECT AND SUBSTANTIAL PROFESSIONAL, FINANCIAL, OR PERSONAL INTEREST IN: <A]

[A> (1) THE PLAN INVOLVED IN THE COMPLAINT, INCLUDING AN OFFICER, DIRECTOR, OR EMPLOYEE OF THE PLAN; OR <A]

[A> (2) THE TREATMENT OF THE ENROLLEE, INCLUDING BUT NOT LIMITED TO THE DEVELOPER OR MANUFACTURER OF THE PRINCIPAL DRUG, DEVICE, PROCEDURE, OR OTHER THERAPY AT ISSUE. <A]

[D> (c) <D] [A> (D) <A] Members of the review panel shall be granted immunity from liability and damages relating to their duties under this section.

[D> (d) <D] [A> (E) <A] An enrollee may be allowed, at the commissioner's discretion, an award of a reasonable sum for attorney's fees and reasonable costs [D> of suit in an action brought against the managed care plan. <D] [A> INCURRED IN CONNECTION WITH THE EXTERNAL REVIEW UNDER THIS SECTION, UNLESS THE COMMISSIONER IN AN ADMINISTRATIVE PROCEEDING DETERMINES THAT THE APPEAL WAS UNREASONABLE, FRAUDULENT, EXCESSIVE, OR FRIVOLOUS. <A]

[A> (F) DISCLOSURE OF AN ENROLLEE'S PROTECTED HEALTH INFORMATION SHALL BE LIMITED TO DISCLOSURE FOR PURPOSES RELATING TO THE EXTERNAL REVIEW. <A] "

[*5] **SECTION 5**. Section 5, Act 178, Session Laws of Hawaii 1998, is amended by amending subsection (c) to

read as follows:

"(c) The task force shall be [D> comprised <D] [A> COMPOSED <A] of interested parties with the total membership of the task [A> FORCE <A] between twelve and [D> twenty <D] [A> TWENTY-SEVEN <A] members. The insurance commissioner or the commissioner's designated representative [D> , <D] shall be a member and serve as the chair of the task force and appoint [D> it <D] [A> ITS <A] remaining members. At least one representative from each of the following shall be appointed as a member; members of other groups may also be appointed:

(1) The department of health;

(2) The department of labor and industrial relations, disability compensation division;

(3) A health insurance company that provides accident and sickness policies under chapter 431, article 10A, Hawaii Revised Statutes;

(4) A mutual benefit society that provides health insurance under chapter 432, Hawaii Revised Statutes;

(5) A health maintenance organization that holds a certificate of authority under chapter 432D, Hawaii Revised Statutes;

(6) The American Association of Retired Persons;

(7) The Hawaii Coalition for Health;

(8) The Hawai'i Business Health Coalition;

(9) The Legal Aid Society of Hawaii;

(10) The Hawaii Medical Association;

(11) An organization that represents nurses; [D> and <D]

(12) A hospital or an organization that represents hospitals [D> . <D] [A> ; AND <A]

[A> (13) HAWAII PSYCHIATRIC MEDICAL ASSOCIATION; <A]

[A> (14) AMERICAN ACADEMY OF PEDIATRICS; AND <A]

[A> (15) FAMILY VOICES. <A] "

PART II

[*6] **SECTION 6**. In Senate Concurrent Resolution No. 152, S.D. 1, the 1999 legislature requested the Hawaii patient rights and responsibilities task force to make a thorough study of the issues relating to the use of the term "medical necessity" and determine the most appropriate definition of "medical necessity", or develop new terms to better resolve the issues examined.

The purpose of this part is to establish a statutory definition of the term "medical necessity" to:

(1) Promote uniformity among the various health plans; and

(2) Serve as the standard of review governing a health plan's internal appeals process and the external appeals process.

[*7] **SECTION 7**. Chapter 432E, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

" [A> SECTION 432E- MEDICAL NECESSITY. (A) FOR CONTRACTUAL PURPOSES, A HEALTH INTERVENTION SHALL BE COVERED IF IT IS AN OTHERWISE COVERED CATEGORY OF SERVICE, NOT SPECIFICALLY EXCLUDED, RECOMMENDED BY THE TREATING LICENSED HEALTH CARE PROVIDER, AND DETERMINED BY THE HEALTH PLAN'S MEDICAL DIRECTOR TO BE MEDICALLY NECESSARY AS DEFINED IN SUBSECTION (B). A HEALTH INTERVENTION MAY BE MEDICALLY INDICATED AND NOT QUALIFY AS A COVERED BENEFIT OR MEET THE DEFINITION OF MEDICAL NECESSITY. A MANAGED CARE PLAN MAY CHOOSE TO COVER HEALTH INTERVENTIONS THAT DO NOT MEET THE DEFINITION OF MEDICAL NECESSITY. <A]

[A> (B) A HEALTH INTERVENTION IS MEDICALLY NECESSARY IF IT IS RECOMMENDED BY THE TREATING PHYSICIAN OR TREATING LICENSED HEALTH CARE PROVIDER, IS APPROVED BY THE HEALTH PLAN'S MEDICAL DIRECTOR OR

PHYSICIAN DESIGNEE, AND IS: <A]

[A> (1) FOR THE PURPOSE OF TREATING A MEDICAL CONDITION; <A]

[A> (2) THE MOST APPROPRIATE DELIVERY OR LEVEL OF SERVICE, CONSIDERING POTENTIAL BENEFITS AND HARMS TO THE PATIENT; <A]

[A> (3) KNOWN TO BE EFFECTIVE IN IMPROVING HEALTH OUTCOMES; PROVIDED THAT: <A]

[A> (A) EFFECTIVENESS IS DETERMINED FIRST BY SCIENTIFIC EVIDENCE; <A]

[A> (B) IF NO SCIENTIFIC EVIDENCE EXISTS, THEN BY PROFESSIONAL STANDARDS OF CARE; AND <A]

[A> (C) IF NO PROFESSIONAL STANDARDS OF CARE EXIST OR IF THEY EXIST BUT ARE OUTDATED OR CONTRADICTORY, THEN BY EXPERT OPINION; AND <A]

[A> (4) COST-EFFECTIVE FOR THE MEDICAL CONDITION BEING TREATED COMPARED TO ALTERNATIVE HEALTH INTERVENTIONS, INCLUDING NO INTERVENTION. FOR PURPOSES OF THIS PARAGRAPH, COST- EFFECTIVE SHALL NOT NECESSARILY MEAN THE LOWEST PRICE. <A]

[A> (C) WHEN THE TREATING LICENSED HEALTH CARE PROVIDER AND THE HEALTH PLAN'S MEDICAL DIRECTOR OR PHYSICIAN DESIGNEE DO NOT AGREE ON WHETHER A HEALTH INTERVENTION IS MEDICALLY NECESSARY, A REVIEWING BODY, WHETHER INTERNAL TO THE PLAN OR EXTERNAL, SHALL GIVE CONSIDERATION TO, BUT SHALL NOT BE BOUND BY, THE RECOMMENDATIONS OF THE TREATING LICENSED HEALTH CARE PROVIDER AND THE HEALTH PLAN'S MEDICAL DIRECTOR OR PHYSICIAN DESIGNEE. <A]

[A> (D) FOR THE PURPOSES OF THIS SECTION: <A]

[A> "COST-EFFECTIVE" MEANS A HEALTH IN-

TERVENTION WHERE THE BENEFITS AND HARMS RELATIVE TO THE COSTS REPRESENT AN ECONOMICALLY EFFICIENT USE OF RESOURCES FOR PATIENTS WITH THE MEDICAL CONDITION BEING TREATED THROUGH THE HEALTH INTERVENTION; PROVIDED THAT THE CHARACTERISTICS OF THE INDIVIDUAL PATIENT SHALL BE DETERMINATIVE WHEN APPLYING THIS CRITERION TO AN INDIVIDUAL CASE. <A]

[A> "EFFECTIVE" MEANS A HEALTH INTERVENTION THAT MAY REASONABLY BE EXPECTED TO PRODUCE THE INTENDED RESULTS AND TO HAVE EXPECTED BENEFITS THAT OUTWEIGH POTENTIAL HARMFUL EFFECTS. <A]

[A> "HEALTH INTERVENTION" MEANS AN ITEM OR SERVICE DELIVERED OR UNDERTAKEN PRIMARILY TO TREAT A MEDICAL CONDITION OR TO MAINTAIN OR RESTORE FUNCTIONAL ABILITY. A HEALTH INTERVENTION IS DEFINED NOT ONLY BY THE INTERVENTION ITSELF, BUT ALSO BY THE MEDICAL CONDITION AND PATIENT INDICATIONS FOR WHICH IT IS BEING APPLIED. NEW INTERVENTIONS FOR WHICH CLINICAL TRIALS HAVE NOT BEEN CONDUCTED AND EFFECTIVENESS HAS NOT BEEN SCIENTIFICALLY ESTABLISHED SHALL BE EVALUATED ON THE BASIS OF PROFESSIONAL STANDARDS OF CARE OR EXPERT OPINION. FOR EXISTING INTERVENTIONS, SCIENTIFIC EVIDENCE SHALL BE CONSIDERED FIRST AND TO THE GREATEST EXTENT POSSIBLE, SHALL BE THE BASIS FOR DETERMINATIONS OF MEDICAL NECESSITY. IF NO SCIENTIFIC EVIDENCE IS AVAILABLE, PROFESSIONAL STANDARDS OF CARE SHALL BE CONSIDERED. IF PROFESSIONAL STANDARDS OF CARE DO NOT EXIST OR ARE OUTDATED OR CONTRADICTORY, DECISIONS ABOUT EXISTING INTERVENTIONS SHALL BE BASED ON EXPERT OPINION. GIVING PRIORITY TO SCIENTIFIC EVIDENCE SHALL NOT MEAN THAT COVERAGE OF EXISTING

INTERVENTIONS SHALL BE DENIED IN THE ABSENCE OF CONCLUSIVE SCIENTIFIC EVIDENCE. EXISTING INTERVENTIONS MAY MEET THE DEFINITION OF MEDICAL NECESSITY IN THE ABSENCE OF SCIENTIFIC EVIDENCE IF THERE IS A STRONG CONVICTION OF EFFECTIVENESS AND BENEFIT EXPRESSED THROUGH UP-TO-DATE AND CONSISTENT PROFESSIONAL STANDARDS OF CARE, OR IN THE ABSENCE OF SUCH STANDARDS, CONVINCING EXPERT OPINION. <A]

[A> "HEALTH OUTCOMES" MEAN OUTCOMES THAT AFFECT HEALTH STATUS AS MEASURED BY THE LENGTH OR QUALITY OF A PATIENT'S LIFE, PRIMARILY AS PERCEIVED BY THE PATIENT. <A]

[A> "MEDICAL CONDITION" MEANS A DISEASE, ILLNESS, INJURY, GENETIC OR CONGENITAL DEFECT, PREGNANCY, OR A BIOLOGICAL OR PSYCHOLOGICAL CONDITION THAT LIES OUTSIDE THE RANGE OF NORMAL, AGE-APPROPRIATE HUMAN VARIATION. <A]

[A> "PHYSICIAN DESIGNEE" MEANS A PHYSICIAN OR OTHER HEALTH CARE PRACTITIONER DESIGNATED TO ASSIST IN THE DECISION MAKING PROCESS WHO HAS TRAINING AND CREDENTIALS AT LEAST EQUAL TO THE TREATING LICENSED HEALTH CARE PROVIDER. <A]

[A> "SCIENTIFIC EVIDENCE" MEANS CONTROLLED CLINICAL TRIALS THAT EITHER DIRECTLY OR INDIRECTLY DEMONSTRATE THE EFFECT OF THE INTERVENTION ON HEALTH OUTCOMES. IF CONTROLLED CLINICAL TRIALS ARE NOT AVAILABLE, OBSERVATIONAL STUDIES THAT DEMONSTRATE A CAUSAL RELATIONSHIP BETWEEN THE INTERVENTION AND THE HEALTH OUTCOMES MAY BE USED. PARTIALLY CONTROLLED OBSERVATIONAL STUDIES AND UNCONTROLLED CLINICAL SERIES MAY BE SUGGESTIVE, BUT DO NOT BY THEMSELVES DEMONSTRATE A CAUSAL RELATIONSHIP UNLESS THE MAGNITUDE

OF THE EFFECT OBSERVED EXCEEDS ANYTHING THAT COULD BE EXPLAINED EITHER BY THE NATURAL HISTORY OF THE MEDICAL CONDITION OR POTENTIAL EXPERIMENTAL BIASES. SCIENTIFIC EVIDENCE MAY BE FOUND IN THE FOLLOWING AND SIMILAR SOURCES: <A]

[A> (1) PEER-REVIEWED SCIENTIFIC STUDIES PUBLISHED IN OR ACCEPTED FOR PUBLICATION BY MEDICAL JOURNALS THAT MEET NATIONALLY RECOGNIZED REQUIREMENTS FOR SCIENTIFIC MANUSCRIPTS AND THAT SUBMIT MOST OF THEIR PUBLISHED ARTICLES FOR REVIEW BY EXPERTS WHO ARE NOT PART OF THE EDITORIAL STAFF; <A]

[A> (2) PEER-REVIEWED LITERATURE, BIOMEDICAL COMPENDIA, AND OTHER MEDICAL LITERATURE THAT MEET THE CRITERIA OF THE NATIONAL INSTITUTE OF HEALTH'S NATIONAL LIBRARY OF MEDICINE FOR INDEXING IN INDEX MEDICUS, EXCERPTA MEDICUS (EMBASE), MEDLINE, AND MEDLARS DATABASE HEALTH SERVICES TECHNOLOGY ASSESSMENT RESEARCH (HSTAR); <A]

[A> (3) MEDICAL JOURNALS RECOGNIZED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES UNDER SECTION 1861(T)(2) OF THE SOCIAL SECURITY ACT, AS AMENDED; <A]

[A> (4) STANDARD REFERENCE COMPENDIA INCLUDING THE AMERICAN HOSPITAL FORMULARY SERVICE-DRUG INFORMATION, AMERICAN MEDICAL ASSOCIATION DRUG EVALUATION, AMERICAN DENTAL ASSOCIATION ACCEPTED DENTAL THERAPEUTICS, AND UNITED STATES PHARMACOPOEIA-DRUG INFORMATION; <A]

[A> (5) FINDINGS, STUDIES, OR RESEARCH CONDUCTED BY OR UNDER THE AUSPICES OF FEDERAL AGENCIES AND NATIONALLY RECOGNIZED FEDERAL RESEARCH INSTITUTES INCLUDING BUT NOT LIMITED TO THE FEDERAL AGENCY

FOR HEALTH CARE POLICY AND RESEARCH, NATIONAL INSTITUTES FOR HEALTH, NATIONAL CANCER INSTITUTE, NATIONAL ACADEMY OF SCIENCES, HEALTH CARE FINANCING ADMINISTRATION, CONGRESSIONAL OFFICE OF TECHNOLOGY ASSESSMENT, AND ANY NATIONAL BOARD RECOGNIZED BY THE NATIONAL INSTITUTES OF HEALTH FOR THE PURPOSE OF EVALUATING THE MEDICAL VALUE OF HEALTH SERVICES; AND <A]

[A> (6) PEER-REVIEWED ABSTRACTS ACCEPTED FOR PRESENTATION AT MAJOR MEDICAL ASSOCIATION MEETINGS. <A]

[A> "TREAT" MEANS TO PREVENT, DIAGNOSE, DETECT, PROVIDE MEDICAL CARE, OR PALLIATE. <A]

[A> "TREATING LICENSED HEALTH CARE PROVIDER" MEANS A LICENSED HEALTH CARE PROVIDER WHO HAS PERSONALLY EVALUATED THE PATIENT. <A] "

* * * * *

HISTORY:

Approved by the Governor June 19, 2000

HAWAII PREPAID HEALTH CARE ACT

HRS § 393-1 Short title.

This chapter shall be known as the "Hawaii Prepaid Health Care Act".

[L 1974, c 210, pt of §1]

HRS § 393-2 Findings and purpose.

The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the em-

ployees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto, provided that presently existing collective bargaining agreements shall not be affected by the provisions of this section.

[L 1974, c 210, pt of §1; am L 1978, c 199, §1]

HRS § 393-3 Definitions generally.

As used in this chapter, unless the context clearly requires otherwise:

* * * * *

(7) "Prepaid health care plan contractor" means:

(A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or

(B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or

(C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

HRS § 393-7 Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits pro-

vided by prepaid health plans of the same type, as specified in section 393-12(a)(1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section 393-11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

(i) Room accommodations;

(ii) Regular and special diets;

(iii) General nursing services;

(iv) Use of operating room, surgical supplies, anesthesia services, and supplies;

(v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:

(i) Covering use of out-patient hospital;

(ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

(A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);

(B) After-care visits for a reasonable period;

(C) Anesthesiologist services.

(3) Medical benefits:

(A) Necessary home, office, and hospital visits by a licensed physician;

(B) Intensive medical care while hospitalized;

(C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio- therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(6) Substance abuse benefits:

(A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting cov-

erage to the mental health or psychiatric benefits of a plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.

(B) Out-patient benefits provided by a physician, psychiatrist, or psychologist, without restriction as to place of service; provided that health plans of the type specified in section 393-12(a) shall retain for the contractor the option of:

(i) Providing the benefits in its own facility and utilizing its own staff, or

(ii) Contracting for the provision of these benefits, or

(iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.

(C) Detoxification and acute care benefits in a hospital or any other public or private treatment facility, or portion thereof, providing services especially for the detoxification of intoxicated persons or drug addicts, which is appropriately licensed, certified, or approved by the department of health in accordance with the standards prescribed by the Joint Commission on Accreditation of Hospitals. In-patient benefits for detoxification and acute care shall be limited in the case of alcohol abuse to three admissions per calendar year, not to exceed seven days per admission, and shall be limited in the case of other substance abuse to three admissions per calendar year, not to exceed twenty-one days per admission.

(D) Prepaid health plans shall not be required to make reimbursements for care furnished by government agencies and available at no cost to a

patient, or for which no charge would have been made if there were no health plan coverage.

* * * * *

HAWAII INSURANCE CODE

HRS § 431:13-105 Power of commissioner

The commissioner may examine and investigate into the affairs of every person engaged in the business of insurance in this State in order to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by section 431:13-102.

* * * * *

HAWAII ADMINISTRATIVE PROCEDURE ACT

HRS § 91-14 Judicial review of contested cases

(a) Any person aggrieved by a final decision and order in a contested case or by a preliminary ruling of the nature that deferral of review pending entry of a subsequent final decision would deprive appellant of adequate relief is entitled to judicial review thereof under this chapter; but nothing in this section shall be deemed to prevent resort to other means of review, redress, relief, or trial de novo, including the right of trial by jury, provided by law.

* * * * *

(b) Except as otherwise provided herein, proceedings for review shall be instituted in the circuit court within thirty days after the preliminary ruling or within thirty days after service of the certified copy of the final decision and order of the agency pursuant to rule of court . . .

* * * * *

(g) Upon review of the record the court may affirm the decision of the agency or remand the case with instructions for further proceedings; or it may reverse or modify the decision and order if the substantial rights of the petitioners may have been prejudiced because the administrative findings, conclusions, decisions, or orders are:

(1) In violation of constitutional or statutory provisions; or

(2) In excess of the statutory authority or jurisdiction of the agency; or

(3) Made upon unlawful procedure; or

(4) Affected by other error of law; or

(5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) Arbitrary, or capricious, or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

* * * * *

HRS § 91-15 Appeals

Review of any final judgment of the circuit court under this chapter shall be governed by chapter 602.

CHAPTER 602

HRS § 602-5 Jurisdiction and powers.

The supreme court shall have jurisdiction and powers as follows:

(1) To hear and determine all questions of law, or of mixed law and fact, which are properly brought before it on any appeal allowed by law from any other court or agency;

* * * * *

MARYLAND INSURANCE CODE

§ 2-210. Hearings

(a) In general. --

(1) The Commissioner may hold hearings that the Commissioner considers necessary for any purpose under this article.

(2) The Commissioner shall hold a hearing:

(i) if required by any provision of this article; or

(ii) on written demand by a person aggrieved by any act of, threatened act of, or failure to act by the Commissioner or by any report, regulation, or order of the Commissioner, except an order to hold a hearing or an order resulting from a hearing.

* * * * *

(c) Applicability of Administrative Procedure Act. --

(1) Except as provided in paragraph (2) of this subsection, a hearing held under this section shall be conducted in accordance with Title 10, Subtitle 2 of the State Government Article (Administrative Procedure Act -- Contested Cases).

(2) A hearing held under this section is not subject to § 10-223 of the State Government Article.

(d) Delegation of hearing authority. -- The Commissioner may delegate to the Deputy Commissioner, an associate deputy commissioner, or an associate commissioner the responsibility for holding a hearing under this section or § 4-114 of this article.

§ 15-10A-03. Review of grievance decision

(a) Commissioner to review grievance decision. --

(1) Within 30 working days after the date of receipt of a grievance decision, a member or a health care provider, who filed the grievance on behalf of the member under § 15-10A-02(b)(2)(iii) of this subtitle, may file a complaint with the Commissioner for review of the grievance decision.

(2) Whenever the Commissioner receives a complaint under this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(3) Except for an emergency case under subsection (b)(1)(ii) of this section, the carrier that is the subject of a complaint filed under paragraph (1) of this subsection shall provide to the Commissioner any information requested by the Commissioner no later than 7 working days from the date the carrier receives the request for information.

(b) Procedures for making decisions. --

(1) In developing procedures to be used in reviewing and deciding complaints, the Commissioner shall:

(i) allow a health care provider to file a complaint on behalf of a member; and

(ii) establish an expedited procedure for use in an emergency case for the purpose of making a final decision on a complaint within 24 hours after the complaint is filed with the Commissioner.

* * * * *

(d) Independent review organization. -- In cases considered appropriate by the Commissioner, the Commissioner may seek advice from an independent review organization or medical expert, as provided in § 15-10A-05 of this subtitle, for complaints filed with the Commissioner under this subtitle that involve a question of whether a health care service provided or to be provided to a member is medically necessary.

* * * * *

§ 15-10A-04. Decisions -- Final decision; notice; hearing; remedies for noncompliance

(a) Issuance of decisions. -- The Commissioner shall:

(1) notwithstanding the provisions of § 15-10A-03(c)(1)(ii) of this subtitle, for the purpose of making final

decisions on complaints, prioritize complaints regarding pending health care services over complaints regarding health care services already delivered;

(2) make and issue in writing a final decision on all complaints filed with the Commissioner under this subtitle that are within the Commissioner's jurisdiction; and

(3) provide notice in writing to all parties to a complaint of the opportunity and time period for requesting a hearing to be held in accordance with § 2-210 of this article.

* * * * *

§ 15-10A-05. Independent review organizations or medical experts

(a) Independent professional judgment. -- For complaints filed with the Commissioner under this subtitle that involve a question of whether the health care service provided or to be provided to a member is medically necessary, the Commissioner may select and accept and base the final decision on a complaint on the professional judgment of an independent review organization or medical expert.

* * * * *

(2) The independent review organization or medical expert shall:

(i) present to the carrier for payment a detailed account of the expenses incurred by the independent review organization or medical expert; and

(ii) provide a copy of the detailed account of expenses to the Commissioner.

(3) The carrier that is the subject of the complaint may not pay and an independent review organization or medical expert may not accept any compensation in addition to the payment for reasonable expenses under paragraph (1) of this subsection.

REVISED STATUTES OF MISSOURI

§ 376.1387. Appeals of grievances determined by the director

1. The director shall resolve any grievance regarding an adverse determination as to covered services appealed by an enrollee or health carrier or plan sponsor through any means not specifically prohibited by law but if the grievance is unresolved by the director then it shall be resolved by referral of such grievance to an independent review organization. The director shall establish the qualifications for such review organizations(s) and shall seek the services of such organization(s) by competitive bid pursuant to chapter 34, RSMo. The director shall enter into contracts with such organization(s) as deemed necessary to conduct the adverse determination appeals process set forth in this section. Any request for an adverse determination appeal shall be assigned on a rotational basis. The organization's decision as to the resolution of the grievance shall be based upon a review of the written record before it. The grievance and resolution of such grievance shall not be considered a contested case within the meaning of section 536.010, RSMo, but the resolution of such grievance by the panel shall be considered a final agency decision within the director's discretion, binding upon the enrollee and health carrier, and subject to judicial review if:

(1) Action for such review is filed within thirty days of the final agency decision; and

(2) Judicial review is limited to the record before the director; and

(3) The enrollee and health carrier are deemed real parties in interest; and

(4) The scope of judicial review extends only to a determination of whether the action of the director is unconstitutional, unlawful, unreasonable, arbitrary, or

capricious or involves an abuse of discretion or is in excess of the statutory authority or jurisdiction of the director.

* * * * *

NEW MEXICO STATUTES

Patient Protection Act

§ 59A-57-4.1. External grievance appeals; appointment; compensation

A. The superintendent may appoint one or more qualified individuals to review external grievance appeals.

B. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations.

C. Upon completion of the external grievance appeal review, the superintendent shall prepare a detailed statement of compensation due each appointee and shall present the statement to the enrollee's health insurer.

D. The enrollee's health insurer shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

E. The superintendent shall promulgate rules to implement this section.

§ 59A-57-9. Private remedies to enforce patient and provider insurance rights; enrollee as third-party beneficiary to enforce rights

A. A person who suffers a loss as a result of a violation of a right protected pursuant to the provisions of the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978], its regulations or a managed health care plan may bring an action to recover actual damages or the sum of one hundred dollars ($ 100), whichever is greater.

B. A person likely to be damaged by a denial of a right

protected pursuant to the provisions of the Patient Protection Act [Chapter 59A, Article 57 NMSA 1978] or its regulations may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damage or intent to violate a right is not required.

New Mexico Administrative Code

13.10.17.23 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

A. Right to external review. Every grievant who is dissatisfied with the results of a medical panel review of an adverse determination by a health care insurer, or with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, may request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

13.10.17.29 INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF

* * * * *

C. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the covered person

was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

* * * * *

13.10.17.30 HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

A. Conduct of hearing. The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico.

* * * * *

B. Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers. If the superintendent designates two (2) independent health care professionals as co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

C. Powers. The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

(1) require the production of additional records, documents, and writings relevant to the subject of the grievance;

(2) exclude any irrelevant, immaterial, or unduly repetitious evidence; and

* * * * *

G. Rights of parties. Both the grievant and the health care insurer have the right to:

(1) attend the hearing. The health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on her behalf if the grievant chooses not to attend personally.

(2) be assisted or represented by an attorney or other person; and

(3) call, examine and cross-examine witnesses.

13.10.17.32 SUPERINTENDENT'S DECISION ON EXTERNAL REVIEW OF ADVERSE DETERMINATION

* * * * *

B. Order. Within the time period allotted for external review, the superintendent shall issue an appropriate order.

(1) The order shall be binding on the grievant and the health care insurer and shall state that the grievant and the health care insurer have the right to judicial review pursuant to NMSA 1978 Section 59A-4-20 and that state and federal law may provide other remedies.

DELAWARE STATUTES

16 Del. C § 9119. Independent health care appeals program

(a) There is established the Independent Health Care Appeals Program in the Department of Health & Social Services. The program will include, at a minimum, a final step in the grievance process which provides for a review by an Independent Utilization Review Organization, hereafter referred to as "IURO," as specified in regulations promulgated by the Department pursuant to the authority granted in § 9110 of this title. The purpose of the program is to provide an independent medical necessity or appropriateness of services review of final decisions of carriers to deny, reduce or terminate benefits in the event the final decision is contested by the covered person.

* * * * *

Should the determination favor the covered person, the health carrier shall have the ability to appeal the issue to Superior Court. The outcome of that appeal shall have no effect on the determination already made by the IURO. In any such instance in which an appeal is taken to the Superior Court, that Court shall, upon receiving notice of the appeal, appoint an independent attorney to defend the determination from which the appeal is taken. The expenses of the appeal to the Superior Court, including the assessment of attorney fees for the attorney appointed by the Court, shall be assessed by the Court against the health carrier. This act will affect "health carriers," defined as any entity subject to insurance laws and regulations of the State. For the purpose of this act, "health carriers" shall be treated as "Managed Care Organizations" as defined in § 9102 of this title.

(b) A covered person may apply to the Independent Health Care Appeals Program for a review of any decision to deny, reduce or terminate covered benefits if the person has already completed the carrier's internal appeals process and the person contests the final decision by the carrier.

* * * * *

(c) The Department shall, at the time of the receipt of the request for an external review, assign an IURO from the list of certified IUROs pursuant to § 9120 (a) of this title and shall so inform the health carrier.

* * * * *

(d) For cases in which the denial, reduction or termination of benefits by the health carrier is based on grounds other than medical necessity or the appropriateness of services, as defined in this section, review from the final decision of the health carrier, following completion of the health carrier's internal review process, shall be through the Department of Insurance in accordance with the provisions of § 332 of Title 18.

(e) For cases in which a denial, reduction or termina-

tion of benefits should be reviewed by both an IURO and by the Department of Insurance, or where there is ambiguity as to where the review should be conducted, the review shall be conducted by an IURO pursuant to this section.

* * * * *

MICHIGAN PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT

§ 550.1905. Scope.

Sec. 5. (1) Except as otherwise provided in subsection (2), this act applies to all health carriers that provide or perform utilization review.

* * * * *

§ 550.1909. Written request to commissioner.

Sec. 9. Except for a request for an expedited external review under section 13, all requests for external review shall be made in writing to the commissioner.

* * * * *

§ 550.1911. Request for external review; commencement; preliminary review; notice of acceptance; duties of commissioner; incomplete request; nonacceptance; assignment of independent review organization; duty of health carrier to provide documents; reconsideration by health carrier of its adverse determination; recommendation; considerations; review by commissioner; notice of decision.

(2) Not later than 5 business days after the date of receipt of a request for an external review, the commissioner shall complete a preliminary review of the request to determine all of the following:

(a) Whether the individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at

the time the health care service was provided.

(b) Whether the health care service that is the subject of the adverse determination or final adverse determination reasonably appears to be a covered service under the covered person's health benefit plan.

* * * * *

(e) Whether the health care service that is the subject of the adverse determination or final adverse determination appears to involve issues of medical necessity or clinical review criteria.

(6) If a request is accepted for external review and appears to involve issues of medical necessity or clinical review criteria , the commissioner shall assign an independent review organization at the time the request is accepted for external review.

* * * * *

(7) If a request is accepted for external review, does not appear to involve issues of medical necessity or clinical review criteria, and appears to only involve purely contractual provisions of a health benefit plan, such as covered benefits or accuracy of coding, the commissioner may keep the request and conduct his or her own external review or may assign an independent review organization as provided in subsection (6) at the time the request is accepted for external review.

* * * * *

§ 550.1915. Decision as final administrative remedy; other remedies.

Sec. 15. (1) An external review decision and an expedited external review decision are the final administrative remedies available under this act. A person aggrieved by an external review decision or an expedited external review decision may seek judicial review no later than 60 days from the date of the decision in the circuit court for the county where the covered person resides or in the circuit court of Ingham county.

Annual External Review Report December 2004

Fore word

Hawaii Revised Statutes ("HRS") section 432E-13 requires the Insurance Commissioner to submit to the legislature a report that contains the number of external review hearing cases reviewed, the type of cases reviewed, a summary of the nature of the cases reviewed, and the disposition of the cases reviewed. Furthermore, the identities of the plan and the enrollee shall be protected from disclosure in the report.

The external review process is an important component to the Patients' Bill of Rights and Responsibilities Act, HRS chapter 432E. As such, the Insurance Division has provided a general overview of the external review statistics for fiscal year 2003-2004.

J.P. SCHMIDT Insurance Commissioner

External Review Report for Fiscal Year 2003-2004

This annual report is filed pursuant to Hawaii Revised Statutes ("HRS") section 432E-13, which requires the Insurance Commissioner to submit an annual report concerning external review cases to the legislature.

The Insurance Division administers the external review process under the Patients' Bill of Rights and Responsibilities Act, HRS chapter 432E ("Act"). The Act provides patients with a mechanism for appealing adverse decisions made by their health plans. After exhausting the health plans' internal appeals process, patients may file a petition for external review with the Insurance Commissioner. If the Commissioner finds that there is good cause for a petition, a hearing is scheduled on the petition. The Insurance Commissioner may conduct the hearing for cases where the amount in controversy is less than $500. Cases in excess of $500 are heard

by a three-member panel, consisting of the Commissioner or his representative, a representative of a health plan not involved in the case, and a practicing physician. The Act also provides for expedited hearings in cases involving serious jeopardy to life or health.

For fiscal year '03-'04 forty (40) external review requests were filed. Nineteen (19) were dismissed, seven were withdrawn, and seven were heard. Three cases were decided in favor of the managed care plan. Four cases were heard and the denial of the managed care plan was overturned. As of September 30, 2004, seven cases were under review.

The nature of cases reviewed is as follows. The majority of the requests involved a denial of coverage. There were twenty-two (22) cases involving denial of coverage; six cases involving level of reimbursement; five cases that failed to meet the 60 day filing requirement; three cases regarding the cancellation of a policy; two regarding the plan's provider network; one regarding a rate increase; and one request for reimbursement timeliness. The following page provides graphs with a breakdown of these cases.

[TABLES NOT REPRODUCED]

(2)

No. 04-1305

Supreme Court, U.S.
FILED
APR 2 8 2005
OFFICE OF THE CLERK

In The
Supreme Court of the United States

KEVIN BALDADO,

Petitioner,

v.

HAWAII MANAGEMENT ALLIANCE ASSOCIATION,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Hawai'i

HAWAII MANAGEMENT ALLIANCE ASSOCIATION'S OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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OR CALL COLLECT (402) 342-2831

CORPORATE DISCLOSURE STATEMENT

Respondent Hawaii Management Alliance Association is a non-governmental corporate party, incorporated in the State of Hawai'i. No individual or public company owns ten percent or more of the stock of the company.

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MISCELLANEOUS

Gretchen Garrison, *House Bill 335-Managed Care in Missouri,* 66 UMKC L. Rev. 775, 797 (1998) 22

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

Pertinent portions of the statutory provisions relied upon by the Petitioner, which were not included as part of the Petitioner's Appendix ("P. App."), are provided in the Appendix hereto (Respondent's Appendix, or "R. App.").

COUNTER-STATEMENT

There is no need for this Court to grant the Petition for Writ of Certiorari filed March 28, 2005 by Petitioner Kevin Baldado (hereinafter "Petition"). The prior rulings of this Court regarding federal preemption of state laws by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* ("ERISA") provide all the guidance required to determine the validity of the Hawai'i external review statute, Haw. Rev. Stat. § 432E-6,[1] and other state laws described by the Petition as "active enforcement" statutes. Petition at 14. The Hawai'i Supreme Court properly applied the ERISA jurisprudence of this Court in its decision in *Hawaii Management Alliance Association v. The Insurance Commissioner, et al.*, 106 Hawai'i 21, 100 P.3d 952 (2004) ("*HMAA*"). That decision does not conflict with the cited decision of the Maryland court of last resort, as the Petition asserts, because the Hawai'i and Maryland statutes have significant differences. Moreover, the Maryland court did not perform the same conflict preemption analysis performed by the Hawai'i court. *See* the discussion *infra* at Section III of the Reasons for Denying the

[1] P. App. at 47a-50a. Haw. Rev. Stat. § 432E-6 is referred to herein as "the Hawai'i statute."

Petition. Petitioner has not established the "compelling reason" required for a writ of certiorari to issue, Sup. Ct. R. 10, and the Petition should be denied.

There is no need for this Court to review the Hawai'i court's decision. Respondent Hawaii Management Alliance Association (hereinafter "HMAA") properly denied coverage for the nonmyeloablative stem cell transplant (bone marrow transplant) sought by Petitioner Kevin Baldado (hereinafter "Petitioner" or "Baldado"). Baldado relied on a single medical journal article as scientific support for the proposed treatment. The article, however, merely reviewed the results of an investigation involving 19 patients and ultimately concluded that the proposed treatment "should remain an investigational approach for the treatment of metastatic renal cell carcinoma." Agency Record on Appeal ("AROA") at 37. It further noted that "additional patients will need to be treated" and "additional patients and more time will be required" to determine the efficacy of the treatment. *Id.* The Hawai'i Insurance Commissioner's panel, convened to review HMAA's decision pursuant to Baldado's request for external review, upheld HMAA's decision. The Commissioner's Order concluded, *inter alia*, that: (1) Baldado's health plan excluded from coverage experimental or investigative therapies; (2) Treatment of advanced renal cell carcinoma with bone marrow transplant was investigational; and (3) HMAA "acted reasonably in denying [bone marrow transplant] treatment for renal cell carcinoma, stage IV, as there is insufficient scientific evidence available at the present time to support the reliability of the requested therapy for [Mr. Baldado's] present condition." Circuit Court Record on Appeal ("ROA") at 294. HMAA did not appeal this decision in its favor, and neither did Baldado. The assertions in the

Petition that Baldado obtained the treatment through other means and regarding his present condition (Petition at 11) are not supported by any evidence in the record.

The appeal through the Hawai'i courts challenged the Commissioner's order requiring that HMAA pay Baldado attorneys' fees, notwithstanding the fact that HMAA had fully prevailed before the Commissioner in the external review process. This Court has characterized the award of attorneys' fees to a non-prevailing party as "a radical departure from established principles requiring that a fee claimant attain some success on the merits before it may receive an award of fees." *Ruckelshaus v. Sierra Club,* 463 U.S. 680, 693 (1983). The interpretation of Haw. Rev. Stat. § 432E-6(e)[2] by the Hawai'i Insurance Commissioner as authorizing the award of attorneys' fees to a non-prevailing party was not only inconsistent with the "established principles" recognized by this Court in *Ruckelshaus*, but was also in direct conflict with ERISA. While ERISA allows for an award of attorneys' fees to either party, the Ninth Circuit has held that attorneys' fee awards may be made only to prevailing parties. *Hummel v. S.E. Rykoff & Co.*, 634 F.2d 446 (9th Cir. 1980) (establishing five factor test). The attorneys' fee provision of the Hawai'i statute also conflicted with ERISA because it allows awards only to the enrollee, and not to the plan. Moreover, the attorneys' fee award was the culmination of an external review process under Hawai'i law, which is entirely preempted by ERISA. On appeal, HMAA argued that ERISA preempted the entirety of the external review statute, Haw. Rev. Stat. § 432E-6, including but not limited to the fee award

[2] P. App. at 50a.

provision in subsection (e). The Hawai'i court correctly concluded that the attorneys' fee provision could not survive the preemption of the remainder of Haw. Rev. Stat. § 432E-6.

There is no support in the record for Petitioner's assertion that "[t]he primary purpose of Hawai'i's external review provision is to invite insureds to submit adverse coverage decisions for the commissioner to review, providing grist for his regulatory mill." Petition at 4. Rather, the Hawai'i external review process is strictly adjudicatory. It provides an alternative process for review of a health plan's benefit determination, including a contested case evidentiary hearing, and authorizes the Commissioner to "issue an order affirming, modifying, or reversing the decision," upon a majority vote of the three member panel assembled to hear the external review. Haw. Rev. Stat. § 432E-6(a)(7).[3] As such, it "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." *Aetna Health, Inc. v. Davila*, 542 U.S. 200, ___, 124 S. Ct. 2488, 2500 (2004) ("*Aetna Health*"), and is preempted.

The discussion in the Petition regarding the Commissioner's ability to reject requests for external review that do not have merit, and the frequency with which he has exercised that discretion, is based on facts that were not a part of the record before the Hawai'i courts. Even if the facts were a matter of public record at the time, that record was not brought to the attention of the Hawai'i courts, so it is not a part of the record on appeal. Petitioner

[3] P. App. at 49a.

did not rely on those facts below, and cannot rely upon them as a basis for this Petition.

Petitioner's discussion of the Hawai'i Prepaid Health Care Act of 1974 ("PHCA"), Petition at 5-6, is not supported by the record in this case, and the impact of the PHCA on the issues in this case, if any, was not argued to the Hawai'i courts. Moreover, the Petition misstates the history of the PHCA. ERISA did not contain an exemption from preemption for the PHCA when it was first enacted. In fact, this Court summarily affirmed the decision of the Ninth Circuit Court of Appeals that the PHCA was preempted by ERISA. *Standard Oil Co. v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), aff'd, 454 U.S. 801 (1981). A subsequent amendment to 29 U.S.C § 1144 created an exemption for the PHCA. 29 U.S.C. § 1144(b)(5)(A). However, any amendment to the PHCA which "provides for more than the effective administration of such Act as in effect on [September 2, 1974]" remains expressly preempted by ERISA. 29 U.S.C. § 1144(b)(5)(B)(ii). Moreover, the exemption for the PHCA was further limited in that it expressly does not apply to any PHCA provisions which conflict with Sections 1 and 4 of Subtitle B of ERISA. 29 U.S.C. § 1144(b)(5)(C). Clearly, neither this Court nor Congress believed that ERISA preemption of conflicting state laws was less of a concern in Hawai'i than elsewhere in the nation, as is asserted in the Petition. While the PHCA imposes a detailed scheme for prepaid health plans to be provided by employers in Hawai'i, the need for consistent procedures and remedies, as provided by ERISA, is as great in Hawai'i as it is anywhere else.

The assertions in the Petition regarding the evolution of the health plan contractor industry in Hawai'i are not supported by any record evidence. Further, the assertion

that the Hawai'i legislature enacted the Patient Bill of Rights and Responsibilities in 1998 "to deal with concerns over the potential for gate-keeping and other abuses" ignores the express language of the preamble to Act 178. In enacting Act 178, the Hawai'i Legislature expressly recognized that "Hawai'i has been fortunate not to experience the questionable practices of certain entities engaging in managed care."[4] The discussion of the work of the task force created by Act 178, Petition at 8-9, is also wholly unsupported by the record, was not argued to the Hawai'i state courts, and thus cannot be relied upon before this Court.

The Petition engages in revisionist history regarding the evolution of Hawai'i's external review law, as is discussed further *infra* in Section II of the Reasons for Denying the Petition.

REASONS FOR DENYING THE PETITION

I. THE QUESTIONS PRESENTED BY THE PETITION WERE NOT RAISED BELOW

The Petition identifies two Questions Presented to this Court. Petition at (i). However, neither of the questions identified in the Petition were properly raised before the state courts. Nor does the Petition comply with the requirements of Rule 14(g) of the Rules of the Supreme Court. The Petition does not specify the stage in the proceedings where the federal questions sought to be reviewed were raised, the manner or method of raising

[4] P. App. at 51a.

them, and the way in which they were passed on by the state courts. Nor does the Petition include pertinent quotations of specific portions of the record where the matter appears, "so as to show the federal question was timely and properly raised and that this Court has jurisdiction to review the judgment on a writ of certiorari." Sup. Ct. R. 14(g).

Petitioner does not make this required showing, because he cannot do so. The basic premise of the first Question Presented by the Petition is that Haw. Rev. Stat. § 432E-6 only "subjects a small number of coverage denials to an adversarial process as part of regulating health plans, but does not provide plan participants a legal right to an independent benefit determination." Petition at (i). The Hawai'i statute was never characterized in that fashion in the proceedings below, nor is there any record evidence to support that characterization. Accordingly, the question of whether a statute so described would "implicate the enforcement scheme of [ERISA] 29 U.S.C.S. § 1132(a) sufficiently to warrant preemption" was never presented to the state courts in the proceedings below. This Court thus has no jurisdiction to review that question.

Similarly, the second Question Presented by the Petition relies upon the premise that "the external review is part of a comprehensive regulatory plan administered by the state agency assigned to police health insurers' compliance with medical necessity and any other state-mandated benefits." Petition at (i). The factual record in this case is devoid of any evidence to support that premise, nor was that argument made to the state courts at any time prior to the filing of Petitioner's motion for reconsideration of the *HMAA* decision. In Appellee Kevin Baldado's

Motion for Reconsideration of the Supreme Court of Hawai'i's Opinion dated November 18, 2004, filed November 29, 2004 ("Motion for Reconsideration"), Petitioner asserted that "§432E-6 is the insurance commissioner's review of the health plan's compliance with §§ 432E-5 and 1.4." Motion for Reconsideration at 6. The Motion for Reconsideration further asserted that, as a result of the Hawai'i court's decision in *HMAA*, "the Insurance Commissioner has no means to enforce §§ 432E-1.4 and 5," *id*, and that "Hawai'i state government has a heightened duty to regulate health care because it forces Hawai'i employers to fund employee health insurance under the Prepaid Health Care Act[.]" *Id*. at 6-7. Those arguments were improperly presented for the first time in the Motion for Reconsideration, and were not supported by any record citations – because there are no facts of record to support them.

Moreover, even if the arguments presented in the Motion for Reconsideration were a proper part of the record on appeal, Petitioner nonetheless failed to preserve for appeal the crux of his second question, "[w]hether the *Rush Prudential* test, providing that external review laws are saved so long as they do not 'so resemble an adjudication as to fall within *Pilot Life*'s categorical bar . . . ' is the appropriate test to apply" to the Hawai'i statute. Petition at (i). Petitioner never argued that *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) ("*Rush Prudential*") was not the appropriate test to determine ERISA preemption in any of his briefing before the state courts. Rather, Petitioner argued that "a perusal of" this Court's decision in *Rush Prudential* was "all that is needed to reject HMAA's preemption argument." Appellee Kevin Baldado's Answering Brief filed in the Hawai'i Supreme Court on

July 9, 2002, at 11. Petitioner continued to argue the controlling effect of the *Rush Prudential* decision for several pages of his brief before the Hawai'i court. *Id.* at 11-13. Far from questioning the proper application of *Rush Prudential* to the analysis of the Hawai'i statute, Petitioner advocated *Rush Prudential* as controlling law. He cannot now seek review of a question that was never presented to the Hawai'i state courts. For this reason alone, the Petition must be denied.

II. THE PETITION MISREPRESENTS THE OPERATION OF THE HAWAI'I STATUTE AND ITS LEGISLATIVE HISTORY

Petitioner's interpretation of Haw. Rev. Stat. § 432E-6 as providing alternative methods of external review, in addition to the three person review panel, is supported by neither the language nor the structure of the statute. It is a novel interpretation of the statute, which was not argued before the state courts which decided this case. Petitioner's argument has not even been advanced by the Insurance Commissioner – who is charged with implementation of the external review process.[5] Even a cursory review of the statutory language confirms that the external review process under the Hawai'i statute is to be performed by a three-member panel.[6] The decision of the

[5] The Insurance Commissioner and the Division of Insurance, Department of Commerce and Consumer Affairs, State of Hawai'i, filed a letter in support of the Petition on April 8, 2005, and indicated they would participate in this case on the merits if the Petition is granted. However, the Commissioner has never advocated the interpretation of the Hawai'i external review statute argued in the Petition.

[6] The only exception is in cases where the amount at issue is less than $500, in which cases the Insurance Commissioner may conduct a

(Continued on following page)

Commissioner is then subject to judicial review under Haw. Rev. Stat. § 91-14: "any person aggrieved by" the outcome of the contested case hearing "is entitled to judicial review thereof." Haw. Rev. Stat. § 91-14(a).[7] As the Hawai'i court in *HMAA* concluded: "a claimant who is denied benefits pursuant to Hawaii's external review law can appeal that denial to the courts, allowing for a judicial determination of the claimant's entitlement to benefits." 106 Hawai'i at 35, 100 P.3d at 966. That aspect of the Hawai'i statute clearly violates the exclusive civil enforcement scheme of ERISA, 29 U.S.C. § 1132(a).

The adjudicatory review by a three-member panel is the only means of conducting the external review under the Hawai'i statute. As the Hawai'i court held in *HMAA*:

> whereas the Illinois statute considered in *Rush Prudential* required one physician to determine whether the proposed procedure was "medically necessary," the Hawai'i statute provides for a three-member panel (only one of whom must be a physician) to determine whether the HMO's actions were "reasonable." These distinctions are fatal to the external review law. The external review hearing more closely resembles "contract interpretation or evidentiary litigation before a neutral arbiter" than "a practice (having nothing to do with arbitration) of obtaining another medical opinion." *Rush Prudential*, 536 U.S. at 383.

106 Hawai'i at 35, 100 P.3d at 966.

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hearing himself, without convening a review panel. Haw. Rev. Stat. § 432E-6(a)(4). P. App. at 48a.

[7] P. App. at 84a.

Petitioner's argument that the Hawai'i statute provides alternatives to the adjudicatory review by a three-member panel invites the Court to focus upon subsection (a)(2) of Haw. Rev. Stat. § 432E-6, and ignore the remainder of the statute. Petition at 17. It is true that subsection (a)(2) allows the Commissioner to retain "an independent medical expert trained in the field of medicine most appropriately related to the matter under review." Haw. Rev. Stat. § 432E-6(a)(2)(A).[8] That provision continues, however, to specify that "[p]resentation of evidence for this purpose shall be exempt from section 91-9(g)." *Id.* Clearly, this provision merely allows the Commissioner to present ***evidence*** from this medical expert to the review panel, even though such evidence was not a part of the record provided by the parties and would otherwise be inadmissible. Haw. Rev. Stat. § 91-9(g) provides that, in a contested case proceeding, "[n]o matters outside the record shall be considered by the agency in making its decision[.]"[9] The statutory reference to presenting evidence from a medical expert does not allow the Commissioner to delegate to a medical expert the responsibility for rendering the decision on the external review.

Haw. Rev. Stat. § 432E-6(a)(2)(B) similarly allows the Commissioner to retain the services of an independent review organization ("IRO") to advise the three-member panel: "The Commissioner may retain . . . [t]he services of an independent review organization from an approved list maintained by the commissioner."[10] However, the services of the IRO must be intended merely to advise the three-member

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[8] P. App. at 47a.

[9] Respondent's Appendix attached hereto ("R. App.") at 1a.

[10] P. App. at 47a.

panel, because there is no authorization in the statute for the IRO to render any "decision." Nor is there any record evidence that the Commissioner maintains an "approved list" of IROs, much less has ever called upon an IRO to assist in the external review function under section 432E-6. Rather, the Hawai'i statute refers only to a decision based upon the vote of the three-member panel. *See* Haw. Rev. Stat. § 432E-6(a)(7) ("The commissioner, upon a majority vote of the panel, shall issue an order affirming, modifying, or reversing the decision" of the managed care plan).[11]

The actual right to external review is expressed in terms of review by a three-member panel:

> After exhausting all internal complaint and appeal procedures available, an enrollee, or the enrollee's treating provider or appointed representative, may file a request for external review of a managed care plan's final internal determination to a three-member review panel appointed by the commissioner.

Haw. Rev. Stat. § 432E-6(a).[12] The statute does not say the request for external review is made to the Commissioner, who will then decide whether the review is to be conducted by a medical expert, an IRO or a three-member review panel. The scope of the external review is also stated in terms of review by the three-member panel: "The review panel shall review every final internal determination to determine whether the managed care plan involved acted

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[11] P. App. at 49a.

[12] P. App. at 47a.

reasonably." Haw. Rev. Stat. § 432E-6(a)(7).[13] There is no support in the statute or the record for the assertion that the Commissioner has discretion to choose among three alternative settings for the external review. Petition at 15, 17, and 18. Nor was this argument ever presented to the Hawai'i court for its consideration.

Where there is good cause shown for an external review, the statute provides that the Commissioner "shall" appoint a review panel:

> Upon receipt of the request for external review and upon a showing of good cause, the commissioner shall appoint the members of the panel and shall conduct a review hearing pursuant to chapter 91. If the amount in controversy is less than $500, the commissioner may conduct a review hearing without appointing a review panel.

Haw. Rev. Stat. § 432E-6(a)(4).[14] Where good cause is shown, the only exception to the requirement to appoint a review panel is where the amount in controversy is less than $500. In that case, the Commissioner is not required to appoint a panel – but he must still conduct a hearing. Contrary to the assertion in the Petition, where good cause is shown, the Hawai'i statute does create a right to an external review hearing.

The fact that the Commissioner is authorized to dismiss a request for external review without hearing, where the Commissioner determines the request to be without merit, does not alter the fact that the external

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[13] P. App. at 49a.

[14] P. App. at 48a.

review by a three-member panel is preempted by ERISA. This is equivalent to a dismissal for failure to state a claim upon which relief can be granted under Rule 12(b)(6) of the Federal Rules of Civil Procedure. The fact that a party's state law cause of action may be subject to dismissal without an evidentiary hearing, where on its face it is without merit, does not save that cause of action from preemption. Moreover, the statistics cited on pages 15 and 20 of the Petition for the number of external review requests rejected by the Commissioner were not brought to the attention of the state courts, and are thus not a part of the record in this case.

Petitioner suggests the Hawai'i court in *HMAA* erred in concluding that the preemption of the fee award provision of Haw. Rev. Stat. § 432E-6(e) necessarily followed from the preemption of the remainder of the Hawai'i statute. Petition at 18-19. Petitioner suggests the fee award provision ought to have survived as a part of the Commissioner's "power to assess sanctions as part of the regulatory function in policing compliance." *Id.* at 19. This argument was not presented to the state courts below. Moreover, Petitioner does not suggest how the Commissioner's exercise of his power to sanction could be warranted where the decision of the health plan is fully validated, as was the case in Petitioner's external review proceeding. In any event, the language of the statute clearly ties the award of attorneys' fees to the external review process. Haw. Rev. Stat. § 432E-6(e) ("An enrollee may be allowed . . . an award of a reasonable sum for attorneys' fees and costs incurred in connection with the

external review under this section").[15] The fee award provision properly fell with the remainder of the section.

The assertion at page 8 of the Petition that the Commissioner was only given the discretion to dismiss frivolous or meritless appeals in the 1999 amendments to the Hawai'i statute is contrary to the record. The provisions allowing the Commissioner to dismiss a request for external review under Haw. Rev. Stat. § 432E-6(a)(4) and (6) pre-existed the amendments to the statute in 1999 and 2000. *See* P. App. at 54a. Accordingly, there is no merit to Petitioner's assertion that the change to the title of the section from "Appeals to the Commissioner" to "External review procedure" suggests some change in the substantive right to a hearing. Petition at 9. The provisions allowing the Commissioner to dismiss a request for external review without hearing existed both before and after the title change.

Petitioner's argument that the primary purpose of the external review process is not to adjudicate the benefits due an enrollee who files a request for external review, but rather to "provide [the Commissioner] grist for his regulatory mill" is wholly unsupported by the statutory language. Petition at 4. Unless a request for external review is dismissed without hearing pursuant to Haw. Rev. Stat. § 432E-6(a)(4) or (6),[16] section 432E-6(a)(7) requires an adjudication based upon the facts of that case:

> The review panel shall review every final internal determination to determine whether the managed care plan involved acted reasonably.

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[15] P. App. at 50a.

[16] P. App. at 48a-49a.

> The review panel and the commissioner or the commissioner's designee shall consider:
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> (A) The terms of the agreement of the enrollee's insurance policy, evidence of coverage, or similar document;
>
> (B) Whether the medical director properly applied the medical necessity criteria in section 432E-[1.4] in making the final internal determination;
>
> (C) All relevant medical records;
>
> (D) The clinical standards of the plan;
>
> (E) The information provided;
>
> (F) The attending physician's recommendations; and
>
> (G) Generally accepted practice guidelines.

Haw. Rev. Stat. § 432E-6(a)(7).[17]

Contrary to Petitioner's assertion, the external review process under Haw. Rev. Stat. § 432E-6 is not simply an avenue for ensuring compliance with the requirement of section 432E-5(a) that a plan apply the medical necessity definition of Haw. Rev. Stat. § 432E-1.4 in its internal complaints and appeals process.[18] The issue to be decided by the review panel is whether the plan "acted reasonably," and the right to external review extends to "every final internal determination" of any "complaint," not only

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[17] P. App. at 49a.

[18] P. App. at 46a.

those involving issues of medical necessity. Haw. Rev. Stat. § 432E-6(a)(7).[19]

Neither the language of the Hawai'i statute nor the record before the state courts support the novel interpretation of Haw. Rev. Stat. § 432E-6 which is advocated in the Petition. The Hawai'i court in *HMAA* fully and properly analyzed the Hawai'i external review statute in a manner consistent with controlling authority of this Court. Petitioner has demonstrated no basis for the Court to agree to hear this case.

III. THE PROCEEDINGS IN THIS CASE DO NOT REFLECT A CONFLICT BETWEEN THE STATES REGARDING AN IMPORTANT FEDERAL QUESTION

Although the Petition argues that the Hawai'i court misinterpreted the Hawai'i statute, the principal basis for seeking a writ of certiorari is the assertion that "[t]he Hawai'i court's decision in this case cannot be reconciled with the opinion of the Maryland Court of Appeals in *Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md.*, 371 Md. 455, 810 A.2d 425 (2002)." Petition at 21. However, that assertion ignores significant differences between the external review statutes of Hawai'i and Maryland, and the different analysis performed by the Hawai'i and Maryland courts. In truth, the two cases are distinguishable on both their facts and their analysis.

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[19] The only complaints excepted from the external review process under the Hawai'i statute are claims of professional malpractice, negligence or fault. Haw. Rev. Stat. § 432E-6(b). P. App. at 49a. A separate external review procedure exists for those medical tort claims under Haw. Rev. Stat. Ch. 671.

The Maryland statute, unlike the Hawai'i statute, applies only to decisions regarding whether a service "is or was not medically necessary, appropriate or efficient." Md. Ins. Code Ann. § 15-10A-01(b)(1)(i) (definition of "adverse decision").[20] *See also id.* at §§ 15-10A-01(d) and (f) (defining "complaint" and "grievance" in terms of "adverse decisions");[21] Md. Ins. Code Ann. § 15-10A-02(d) (Commissioner to review "complaints" and "grievances");[22] Md. Ins. Code Ann. § 15-10A-03 ("Review of grievance decision").[23] By contrast, the Hawai'i statute provides for the review of any "final internal determination" of a managed care plan. Haw. Rev. Stat. § 432E-6(a).[24] The Hawai'i statute requires managed care plans to issue a "final internal determination" regarding any "complaint" by a member. Haw. Rev. Stat. § 432E-5(d).[25] A "complaint" is defined by Hawai'i law as "an expression of dissatisfaction, either oral or written." Haw. Rev. Stat. § 432E-1.[26] The reach of the Hawai'i statute is thus much broader than the Maryland statute, as it covers far more than medical necessity issues.

Further, the initial decision regarding medical necessity on an external review under Maryland law is made by the Commissioner, or by an IRO selected by the Commissioner. Md. Ins. Code Ann. §§ 15-10A-03(a) and (d).[27] There

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[20] R. App. at 1a.

[21] R. App. at 2a.

[22] R. App. at 2a-3a.

[23] P. App. at 86a.

[24] P. App. at 47a. The only exceptions are medical tort claims, pursuant to Haw. Rev. Stat. § 432E-6(b). P. App. at 49a.

[25] P. App. at 46a.

[26] R. App. at 1a.

[27] P. App. at 86a-87a.

is no evidentiary hearing, unless one is requested by either party after reviewing the Commissioner's decision. Md. Ins. Code Ann. §§ 15-10A-03(e)(2) and (4) (specifying information to be considered by the Commissioner);[28] Md. Ins. Code Ann § 15-10A-04(a)(3).[29] This external review process much more closely resembles the Illinois statute upheld by this Court in *Rush Prudential* than does the Hawai'i statute. Under Hawai'i law, the first level of external review by the Insurance Commissioner involves an evidentiary hearing before a three-member panel, only one of whom is required to be a licensed physician. Haw. Rev. Stat. § 432E-6(a).[30] As noted above, Petitioner's assertion that the Hawai'i Commissioner has the option of referring an external review to an IRO rather than conducting a hearing before a three-member panel is contrary to the language and operation of the statute. Under the Hawai'i statute, a request for external review of a managed care plan's decision, which is not dismissed for lack of merit, is decided following an evidentiary hearing before a three-member panel – much like an arbitration. Haw. Rev. Stat. § 432E-6(a). *Id.*

It is true that both the Hawai'i and Maryland statutes provide for judicial review of the administrative decision rendered by the Insurance Commissioner. That is an aspect of the Hawai'i statute which was important to the Hawai'i court in deciding that Haw. Rev. Stat. § 432E-6 was preempted by ERISA. The Hawai'i court performed a detailed analysis of the conflict between the Hawai'i statute and the exclusive judicial enforcement scheme of

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[28] R. App. at 4a.

[29] P. App. at 88a.

[30] P. App. at 47a.

ERISA, as contained in 29 U.S.C. § 1132(a). 106 Hawai'i at 31-36, 100 P.3d at 962-967. That same analysis, if applied to the Maryland statute, may well have resulted in a finding that the Maryland statute is preempted by ERISA. However, the decision of the Maryland court does not conflict with the decision of the Hawai'i court on this key point because the Maryland court did **not** perform a conflict analysis with respect to section 1132(a). Indeed, there is no indication in the Maryland court's decision that it was asked to conduct such a conflict analysis, or that either party had raised such an issue as part of the appeal. The majority of the Maryland court's analysis was devoted to its conclusion that the Maryland statute was saved from express preemption under 29 U.S.C. § 1144 as a statute regulating insurance. 371 Md. at 463-470, 810 A.2d at 430-433. The only conflict preemption analysis performed by the Maryland court was with respect to an ERISA regulation governing claims procedures *internal* to the plan, 29 C.F.R. § 2560.503-1. 371 Md. at 468, 471, 810 A.2d at 432, 434. That regulation has no bearing on whether a state process for *external* review, following the exhaustion of the internal review process afforded by a plan, is preempted by ERISA.

The Petition also asserts that a number of other states, in addition to Hawai'i and Maryland, have enacted "active enforcement" statutes, and argues the need for guidance to those states as a basis for the Petition. Petition at 24-26. It is not clear how the state courts of last resort in these jurisdictions would rule if presented with an argument that their external review statutes were preempted by ERISA. The state courts have not yet

spoken regarding this issue.[31] There are thus no conflicting decisions regarding the question of ERISA preemption of the statutes in those states which could justify the current Petition. Sup. Ct. R. 10(b). A conflict should not be assumed where the state's own courts have not yet had opportunity to speak on these issues. Even the law review article the Petition represents as discussing "the Missouri law's vulnerability to ERISA preemption" merely states that an ERISA preemption analysis should be conducted

---

[31] It is true that the other state statutes discussed in the Petition resemble the Hawai'i and/or Maryland statutes to varying degrees. However, Petitioner's assertion that these statutes have much in common with the Hawai'i statute fails to note the significant differences among the various statutory schemes. Missouri (R. App. at 5a) and New Mexico (P. App. at 91a-92a) review only issues of medical necessity, like the Maryland statute, while Delaware (P. App. at 93a-94a) and Michigan (P. App. at 96a) review a broad range of issues, similar to the Hawai'i scheme. The other state statutes cited by Petitioner are divided regarding whether the external review is on the record (Missouri, P. App. at 89a, and Michigan, R. App. at 9a-11a), or involves an evidentiary hearing (New Mexico, P. App. at 91a-93a, and, in some cases, Delaware). External review of medical necessity determinations in Delaware is performed by an Independent Utilization Review Organization ("IURO"), and thus likely does not involve a hearing. P. App. at 93a-94a. However, external review of issues other than medical necessity or the appropriateness of services is accomplished in Delaware through an arbitration process. R. App. at 7a-8a. The Delaware statute regarding such arbitrations provides for a hearing to be held. *Id.* With respect to judicial review, the decision following the external review is final and binding on the plan under three of the four statutory schemes (Missouri, P. App. at 89a; New Mexico, P. App. at 93a; Delaware, R. App. at 8a), but is binding on the member under only two of the statutes (Missouri, P. App. at 89a; New Mexico, P. App. at 93a). A decision upholding the plan's determination only gives rise to a rebuttable presumption in a subsequent action by a member in Delaware, thus appearing to preserve the ERISA remedy. R. App. at 8a. The Michigan statute expressly preserves remedies under state and federal law for the member, and under state law for the plan. R. App. at 12a.

by a prospective plaintiff. Gretchen Garrison, *House Bill 335-Managed Care in Missouri*, 66 UMKC L. Rev. 775, 797 (1998) ("An exhaustive discussion of ERISA preemption is beyond the scope of this article."). Accordingly, the only state court decisions before the Court on this Petition are the decisions of the Hawai'i and Maryland courts, and as discussed above, those decisions are easily distinguished. There is no conflict justifying a writ of certiorari.

Finally, the timing of the decisions rendered by the Hawai'i and Maryland courts provides a further basis for distinguishing the cases asserted to be indistinguishable by the Petition. The decision of the Maryland court was rendered before this Court issued its decision in *Aetna Health*, while the Hawai'i court had the benefit of that decision in performing its analysis. The guidance provided by the Court in *Aetna Health* for determining whether a state law would violate ERISA should resolve any confusion regarding the validity of the "active enforcement" external review schemes enacted in Hawai'i, Maryland, and the other states discussed in the Petition. As discussed above, *Aetna Health* confirmed that the preemptive effect of ERISA extends to any state law that "provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 542 U.S. at __, 124 S. Ct. at 2500. If the state has provided "a separate vehicle to assert a claim for benefits outside of . . . ERISA's remedial scheme," that statute is preempted. It is not necessary for this Court to grant the Petition in order to provide additional guidance on that point.

CONCLUSION

For the foregoing reasons, Respondent Hawaii Management Alliance Association respectfully requests that the Court deny the petition for a writ of certiorari.

Respectfully submitted,

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HAWAII REVISED STATUTES

§91-9 Contested cases; notice; hearing; records. . . .

* * *

(g) No matters outside the record shall be considered by the agency in making its decision except as provided herein.

§432E-1 Definitions. As used in this chapter, unless the context otherwise requires:

* * *

"Complaint" means an expression of dissatisfaction, either oral or written.

MARYLAND INSURANCE CODE

§ 15-10A-01. Definitions

(a) In general. – In this subtitle the following words have the meanings indicated.

(b) Adverse decision. –

(1) "Adverse decision" means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

(i) a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and

(ii) may result in noncoverage of the health care service.

(2) "Adverse decision" does not include a decision concerning a subscriber's status as a member.

* * *

(d) Complaint. – "Complaint" means a protest filed with the Commissioner involving an adverse decision or grievance decision concerning the member.

* * *

(f) Grievance. – "Grievance" means a protest filed by a member or a health care provider on behalf of a member with a carrier through the carrier's internal grievance process regarding an adverse decision concerning the member.

(g) Grievance decision. – "Grievance decision" means a final determination by a carrier that arises from a grievance filed with the carrier under its internal grievance process regarding an adverse decision concerning a member.

§ 15-10A-02. Internal grievance process

* * *

(d) Filing complaints with the Commissioner. –

(1)(i) A member or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if the member or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member or a health care provider may file a complaint with the Commissioner if the member or the health care provider does not receive a grievance decision from the carrier on or before the 30th working day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

* * *

(f) Notification. – For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) document the adverse decision in writing after the carrier has provided oral communication of the decision to the member or the health care provider acting on behalf of the member; and

(2) send, within 5 working days after the adverse decision has been made, a written notice to the member and a health care provider acting on behalf of the member that:

* * *

(v) includes the following information:

1. that the member or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 30 working days after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner[.]

§ 15-10A-03. Review of grievance decision

* * *

(e) Burden of proof. –

(1) A carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct:

(i) during the review of a complaint by the Commissioner or a designee of the Commissioner; and

(ii) in any hearing held in accordance with § 2-210 of this article.

(2) As part of the review of a complaint, the Commissioner or a designee of the Commissioner may consider all of the facts of the case and any other evidence that the Commissioner or designee of the Commissioner considers appropriate.

* * *

(4) (i) Except as provided in subparagraph (ii) of this paragraph, in responding to a complaint, a carrier may not rely on any basis not stated in its adverse decision or grievance decision.

(ii) The Commissioner may allow a carrier, a member, or a health care provider filing a complaint on behalf of a member to provide additional information as may be relevant for the Commissioner to make a final decision on the complaint.

(iii) The Commissioner's use of additional information may not delay the Commissioner's decision on the complaint by more than 5 working days.

REVISED STATUTES OF MISSOURI

§ 376.1350. Definitions

For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

* * *

(6) "Clinical review criteria", the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

* * *

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

DELAWARE STATUTES

16 Del. C. § 9119. Independent health care appeals program

(a) . . . For the purpose of this act, "medical necessity" means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, or disease or its symptoms, in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Consistent with the symptoms or treatment of the condition; and

(3) Not solely for anyone's convenience.

The appeal review shall include any decisions regarding covered benefits by the covered person's health benefits plan, and any determination by the IURO shall be binding on the health carriers. If the IURO makes a determination in favor of the carrier, it will give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision.

18 Del. C. § 332. Arbitration of disputes involving health insurance coverage

(a) The following definitions shall apply with respect to this section:

(1) "Adverse determination" means a benefit denial, reduction or termination, a denial of certification, or both.

(2) "Benefit denial" means the denial, in whole or in part, of payment or reimbursement for health care services rendered or health care supplies provided to any person claiming benefits under an insurance policy delivered or issued for delivery in Delaware.

* * *

(9) "Internal review process" or "IRP" means the procedure for an internal review of an adverse determination pursuant to subsection (b) of this section.

* * *

(e) With respect to adverse determinations that are subject to review by the Department of Insurance pursuant to § 9119(d) of Title 16, the Insurance Commissioner shall develop regulations providing for arbitration of such adverse determinations. Such regulations shall contain the following provisions:

(1) Requests for arbitration shall be in writing and mailed to the Commissioner within 60 days of the receipt of the written statement referred to in subdivision (c)(7) of this section.

(2) Arbitrators shall be chosen from an appropriate panel of arbitrators, and hearings shall be conducted according to rules established by the Department of Insurance.

(3) The arbitrator shall review written arbitration requests prior to holding any hearing or allowing any exchange of information between the parties in order to determine whether a written arbitration request is meritless on its face, and may summarily dismiss meritless requests for arbitration.

(4) Neither party shall be held to have waived any of its rights to seek relief in a court of law with respect to a covered person's legal rights to benefits by an act relating to arbitration or the rendering of an arbitration decision.

(5) Arbitration decisions shall be rendered within 45 days of the Commissioner's receipt of an arbitration request.

* * *

(g) If the arbitrator makes a decision in favor of the carrier, that decision shall give rise to a rebuttable presumption to that effect in any subsequent action brought by or on behalf of the covered person with respect to the decision. Should the decision favor the covered person, the carrier shall have the right to appeal the matter to the Court, in accordance with Court rules. The outcome of that appeal, however, shall have no effect on the covered person, as to whom the decision of the arbitrator shall control. The assignment of counsel for an appeal by the carrier and the payment of expenses of that assigned counsel shall be as set forth in § 9119(a) of Title 16.

MICHIGAN LAWS

§ 550.1903. Definitions.

* * *

Sec. 3. As used in this act:

(a) "Adverse determination" means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

§ 550-1911 Request for external review; commencement; preliminary review; notice of acceptance; duties of commissioner; incomplete request; nonacceptance; assignment of independent review organization; duty of health carrier to provide documents; reconsideration by health carrier of its adverse determination; recommendation; considerations; review by commissioner; notice of decision.

Sec. 11. . . .

* * *

(7) . . . Except as otherwise provided in subsection (16), if the commissioner keeps a request, he or she shall review the request and issue a decision upholding or reversing the adverse determination or final adverse determination within the same time limits and subject to all other requirements of this act for requests assigned to an independent review organization. If at any time during the commissioner's review of a request it is determined that a request does appear to involve issues of medical necessity

or clinical review criteria, the commissioner shall immediately assign the request to an independent review organization approved under this act to conduct external reviews.

* * *

(9) Not later than 7 business days after the date of the notice under subsection (4)(b), the health carrier or its designee utilization review organization shall provide to the reviewing entity the documents and any information considered in making the adverse determination or the final adverse determination. Except as provided in subsection (10), failure by the health carrier or its designee utilization review organization to provide the documents and information within 7 business days shall not delay the conduct of the external review.

* * *

(11) The reviewing entity shall review all of the information and documents received under subsection (9) and any other information submitted in writing by the covered person or the covered person's authorized representative under subsection (4)(a) that has been forwarded by the commissioner. Upon receipt of any information submitted by the covered person or the covered person's authorized representative under subsection (4)(a), at the same time the commissioner forwards the information to the independent review organization, the commissioner shall forward the information to the health carrier.

* * *

(13) In addition to the documents and information provided under subsection (9), the reviewing entity, to the extent the information or documents are available and the

reviewing entity considers them appropriate, shall consider the following in reaching a recommendation:

(a) The covered person's pertinent medical records.

(b) The attending health care professional recommendation.

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative, or the covered person's treating provider.

(d) The terms of coverage under the covered person's health benefit plan with the health carrier.

(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.

(f) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization.

* * *

(17) Upon receipt of a notice of a decision under subsection (16) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

§ 550.1915. Decision as final administrative remedy; other remedies.

Sec. 15 . . .

* * *

(2) Subsection (1) does not preclude a health carrier from seeking other remedies available under applicable state law.

(3) Subsection (1) does not preclude a covered person from seeking other remedies available under applicable federal or state law.

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(3)

Supreme Court, U.S.
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No. 04-1305

In The
Supreme Court of the United States

KEVIN BALDADO,

Petitioner,

v.

HAWAII MANAGEMENT ALLIANCE ASSOCIATION,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of Hawai'i

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INTRODUCTION

Every state in the nation is presently trapped between the duty to protect consumers and regulate insurance, and the problem of sufficiently avoiding a conflict with ERISA's enforcement scheme. Those with passive enforcement schemes may follow the guidance this Court provided in *Rush Prudential*.[1] The *Rush Prudential* test is **not** appropriate for the active enforcement schemes. The appropriate test for those cases would focus on differentiating schemes primarily purposed with regulation from those primarily purposed with providing a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

Thus, a new test would apply in circumstances in which the state official in charge of regulating insurance or health is granted original jurisdiction involving complaints about benefit or coverage determinations because the presumption should arise that the primary purpose of such a law is regulation. A health insurer or HMO challenging the state official's jurisdiction on ERISA preemption grounds should be required to show by clear and convincing proof that the primary purpose of the law is to provide a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme. The burden of proving a sufficient resemblance to a separate vehicle will, of course, never be met unless the challenger can show that the law provides the adjudicatory resources necessary to process any claim that might otherwise be asserted under ERISA, and absent such a showing it will be of no consequence that state law permits a party to seek judicial review of the agency determination if state law otherwise affords a right to judicial review of agency decisions.

The application of *Rush Prudential* in cases of active regulation has already proven to produce unreliable and conflicting results. The Maryland and Hawai'i high courts

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[1] *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 122 S. Ct. 2151, 153 L. Ed. 2d 375 (2002).

came to opposite conclusions applying *Rush Prudential* to their respective states' statutory schemes, which are alike in the relevant and material respects. The Opposition Brief failed to provide any substantive reason why Maryland's law, which provides a right of judicial review, should escape preemption while Hawai'i's should be preempted for the very reason that it provides a right of judicial review. Unless this Court resolves the conflict, the future will see further confusion while the various states implementing active regulatory schemes or modifying their existing schemes endeavor to copy Maryland's model (which was held not to be preempted), and avoid resemblance to Hawai'i's approach even though the two schemes are substantially alike.

A. The Hawai'i Court Expressly Ruled on the Questions Presented to This Court

While this Court's traditional rule has precluded a grant of certiorari only when "the question presented was not pressed or passed upon below. . . ." *see, i.e., United States v. Williams*, 504 U.S. 36, 41 (1992), it does not require as a condition of granting a petition that the questions be stated exactly as they were to the court below. Thus in *Stevens v. Department of Treasury*, 500 U.S. 1 (1991), this Court rejected the Solicitor General's argument that it had improvidently granted certiorari because the petitioner did not "present the merits of the timeliness issue to the Court of Appeals . . . ". *Id.* at 8 (holding District Court had decided timeliness issue when it undertook to hear case on the merits; and Court of Appeals likewise decided substantive issue but "answered the timeliness question incorrectly.") Indeed, this Court has held that a federal question is preserved if it is merely *clearly implied* from the record as a whole that the federal question was adequately presented in the state court proceedings. *Webb v. Webb*, 451 U.S. 493, 496 (1981).

The Petition exactly complies with the rule because the **Questions Presented** are drawn directly from the substance of the Hawai'i court's published opinion. First, the Hawai'i court's discussion makes it abundantly clear

that it considered whether Hawai'i's external review law, HRS § 432E-6, implicated ERISA's enforcement scheme sufficiently to warrant preemption. The court noted that "HMAA also argued that the federal courts had repeatedly held that ERISA preempts claims under state laws and that Hawai'i's enforcement scheme directly interferes with the rights HMAA has under ERISA." App. at 30a.[2] Moreover, the Hawai'i court ultimately held that ERISA preempts Hawai'i's external review law based on its erroneous conclusion that petitioners have the "right . . . to seek judicial review." App. at 26a.

As for the second **Question Presented**, the Hawai'i court's published opinion clearly implies that it considered the appropriateness of the *Rush Prudential* test. The court concluded, erroneously, that HRS § 432E-6 "so resembles an adjudication as to fall within *Pilot Life*'s[3] categorical bar . . . " App. at 24a, and apparently that HRS § 432E-6 provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme. App. at 25a-26a. Thus, the Petition has met this Court's requirements for consideration in the case of both of the **Questions Presented**.

Similarly mystifying is Respondent's argument that Petitioner should be denied a review based upon Rule 14(g) because he has not asserted that this Court has jurisdiction based on his timely raising of a federal question in the Hawai'i court.[4] Respondent was the appellant in the Hawai'i court, and the jurisdictional concern of Rule 14(g) was thus satisfied because Respondent based its appeal to the Hawai'i courts on an issue of federal law. The purpose of Rule 14 is to assure that the federal question was properly presented to the state court. *See Howell v. Mississippi*, 160 L. Ed. 2d 873, 879 (2005). It was hardly Petitioner's obligation to raise a question of federal law, but unquestionably the Hawai'i high court's decision was

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[2] Citations to "App. at ##a" refer to the respective pages in the Appendix to the Petition.

[3] *Pilot LIfe Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

[4] The Petition discusses the fact that Respondent's appeal from the Commissioner's order was based on a federal question. *See* Petition at 12.

based on federal law, and in fact reversed a lower court decision in Petitioner's favor rejecting Respondent's federal preemption arguments.[5]

B. Petitioner Correctly Interpreted the Hawai'i External Review Law HRS § 432E-6

Hawai'i's exemption from 29 U.S.C.S. § 1144(a) compels a different standard for Hawai'i with respect to ERISA preemption because ERISA was designed for voluntary employee benefit plans which employers are free to arrange and negotiate with plan administrators and benefit providers as they see fit. Employee health insurance coverage in Hawai'i is mandatory and the coverage provided must comply with the minimum benefits the law requires.[6] Hawai'i laws granting regulators jurisdiction over questions involving eligibility determinations and the interpretation of coverage contracts should be saved from preemption because their primary purpose is ensuring that managed care plans selling statutorily mandated coverage actually provide the benefits to which employees are entitled by the Prepaid Health Care Act. The attempt by Hawai'i's prepaid health plan contractors to use ERISA preemption as a shield against the Insurance Commissioner's oversight of their benefit determinations and interpretations of eligibility and coverage is directly at odds with the realization of the goals of the Prepaid Health Care Act which Congress expressly chose to exempt in Hawai'i's case from the operation of 29 U.S.C. § 1144(a).

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[5] Respondent's discussion of the Insurance Commissioner's review of its benefit denial, Opposition Brief at 2, is irrelevant as this case arose from the Commissioner's order awarding Petitioner his attorneys' fees and costs in connection with the review of the benefit denial. Respondent profited from the circumstance in which the merits of its position were never tested because Medicaid paid for Petitioner's urgently needed treatment before an appeal could be taken.

[6] The Opposition Brief, at 5, misstates the Petition's comments about Hawaii's Prepaid Health Care Act, H.R.S. Chap. 393. The Petition correctly states, "Congress added 29 U.S.C.S. § 1144 to federal law in 1983, exempting the PHCA from preemption by ERISA." Petition at 5. Petitioner's point required no additional historical facts.

Respondent concedes that the Hawai'i court's decision in this case was wrong unless HRS § 432E-6 provides all health insurance beneficiaries with an "actual right" to a review by a three-member panel.[7] The essential provisions that were never incorporated into HRS § 432E-6 explain and further confirm that the statute was not intended to provide such a right to a review. If the Legislature intended for all beneficiaries to have an "actual right" to an alternative enforcement scheme, it was grossly negligent in providing the Commissioner with the necessary resources.

With more than three-quarters of a million insureds in the State, the number of hearings by three-member panels, each of which must include one practicing physician, could easily exceed in any given fiscal year the total number of physicians eligible to serve on a review panel. HRS § 432E-6 provides no authority for the Commissioner to compensate the physician panelists, and in fact Respondent would have to concede that the physicians and insurance industry panelists are always volunteers. Furthermore, HRS § 432E-6 omits to provide the Commissioner with any other adjudicatory resources necessary to enable him to hold hearings on the hundreds – and potentially thousands – of petitions that might be filed in any year. HRS § 432E-6 does, however, grant the Commissioner broad discretionary powers to determine whether a petition will be granted a hearing at all, and therein lies the explanation of the omitted resources.

Likewise, had the Legislature intended to provide an alternative to ERISA's enforcement scheme, its failure to provide the due process necessary to constrain the Commissioner's discretion would also constitute gross negligence. The federal and state courts sharing concurrent jurisdiction over actions under 29 U.S.C. § 1132(a) are not accorded the complete unreviewable discretion to summarily reject a complaint *sua sponte*. Respondents concede, however, that the Commissioner has the power to reject

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[7] Opposition Brief at 12.

petitions *sua sponte*, and that HRS § 432E-6 provides no mechanism for a review of such decisions.[8] The Commissioner's interpretation of the statute, that it does not confer an actual right to external review, explains why the Legislature provided no appeal for petitions the Commissioner rejects.[9]

Further, HRS § 432E-6(a)(2) can only be read as providing the Commissioner with two alternatives to proceeding with a hearing by a three-member panel on petitions he decides to consider. App. at 47a. Respondent asserts that HRS § 432E-6(a)(2) provides the Commissioner with a means to obtain evidence to present to an external review panel. The Commissioner cannot, however, function both as the ultimate decision maker and a party – or some other role-player – presenting evidence to the three-member external review panel. Respondent's assertions concerning the alternative processes HRS § 432E-6(a)(2) affords the Commissioner are thus utter nonsense.[10]

The exemption from HRS § 91-9(g) provided by HRS § 432E-6(a)(2)(A) is also easily explained in light of the Commissioner's true role as the ultimate decision maker. The Hawai'i Administrative Procedure Act ("HAPA") does not permit the Commissioner to consider any evidence not in the record in reaching a decision in a contested case, and a request for external review under HRS § 432E-6(a) nominally meets the definition of contested cases under Hawai'i law because a petitioning beneficiary is contesting a managed care plan's determination. The exemption from the HRS § 91-9(g) prohibition against the Commissioner's consideration of evidence outside the record from the

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[8] Respondent's likening of the Commissioner's discretionary power to the established court process for dismissal for failure to state a claim is absurd. Opposition Brief at 14.

[9] Whether or not the record below expressly includes the fact that the Insurance Commissioner possesses such complete discretionary power, and has exercised it in a majority of cases since July 2000, it is undisputed that it was a matter of public knowledge when the Hawaii court heard Respondent's appeal.

[10] Opposition Brief at 11-12.

internal appeal allows him to obtain the expertise needed to determine whether the plan's determination complied with the law without having to resort to a hearing by a three-member panel.

Moreover, the Commissioner need not retain a medical expert if he decides to have the case heard by a three-member panel because the parties would be permitted to provide expert testimony as part of that proceeding. Likewise, HRS § 432E-6(a)(2)(B) does not suggest in any way that the Commissioner's authority to retain an independent review panel is for the purpose of providing advice to the three-member panel. The independent review organization and the three-member panel serve precisely similar purposes, providing the Commissioner with an opinion on which he can make a determination in the case. Furthermore, Respondent's assertion the Legislature intended the Commissioner to provide an independent opinion to the panel whose sole purpose is providing him with an opinion for his ultimate decision is similarly irrational.

Respondent's assertion – found in footnote 5, Opposition Brief at 9 – that the Commissioner has not interpreted HRS § 432E-6 consistent with its obvious construction, is not entitled to any credit. In their Rule 12.6 letter dated April 8, 2005, the "State Defendants" (the Insurance Commissioner, Division of Insurance, Department of Commerce and Consumer Affairs, and the State of Hawai'i) confirmed their complete support of the Petition:

> State Defendants submit this letter to notify this Court that they intend to remain a respondent party in this case, **that they *support* the petition for certiorari filed by Petitioner Kevin Baldado**, that they submit this letter in lieu of a formal brief in support (given that their support is expressed in only a single sentence), and that in the event certiorari is granted, State Defendants intend to participate in this case on the merits.

(Emphasis in the original).

C. The Maryland and Hawai'i Statutory Schemes Are Alike in the Material Respects

Respondent concedes that both the Hawai'i and Maryland statutory schemes similarly provide the right to judicial review of decisions in contested case hearings.[11] Because the Hawai'i court determined that this feature was "fatal" to Hawai'i's law with respect to preemption, App. at 25a, and the Maryland court did not, the two decisions inherently conflict. Respondent's attempts to distinguish the Hawai'i and Maryland schemes in other respects misstate the elements of the laws in both states, and are thus unavailing.

First, the coverage of the Hawai'i and Maryland schemes appears to be essentially the same. In discussing Maryland's statutory scheme, the court in *Conn. Gen.* held that:

> The Commissioner. . . . makes a determination of whether the service *was covered and medically necessary*. The decision concerning medical necessity may be based "on the professional judgment of an independent review organization or medical expert." § 15-10A-05(a).

Conn. Gen. Life Ins. Co. v. Ins. Comm'r for Md., 371 Md. 455, 459, 810 A.2d 425, 427 (Md. 2002) (emphasis added). Respondent's assertion that "[t]he Maryland statute, unlike the Hawai'i statute, applies only to decisions regarding whether a service 'is or was not medically necessary appropriate or efficient' . . . " thus understates the scope of the Maryland commissioner's jurisdiction.

Respondent further concedes that under Maryland law, a party has the **right** to a contested case hearing.[12] Maryland's law thus apparently more closely resembles a separate vehicle to assert a claim for benefits outside of

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[11] Opposition Brief at 20-21.

[12] "Once Maryland's commissioner issues an order in connection with the external review, all parties are given the opportunity to request an administrative hearing pursuant to Md. Code Ann., Ins. § 2-210A-01." Petition at 22.

ERISA's remedial scheme than does Hawai'i's, because the Hawai'i Commissioner's unreviewable authority to deny a requested contested case hearing cuts off the "right" to judicial review for all rejected petitions.[13]

The three purposes of the 146-word Illinois statute in *Rush Prudential* are to provide every insured, without exception, with the right to a second opinion, to require the HMO to provide the benefit if the second opinion determines it to be medically necessary, and to provide physicians giving second opinions some measure of protection from being discriminated against by the HMO. *See* App. at 41a-42a. The Illinois statute does not refer to a right of judicial review. There is no right to a second opinion under either the Hawai'i or the Maryland laws. As set forth above, court in *Conn. Gen.* held that the Maryland commissioner's "decision concerning medical necessity *may* be based 'on the professional judgment of an independent review organization or medical expert.'" § 15-10A-05(a)." *Conn. Gen.*, 371 Md. at 459 (emphasis added). Likewise, HRS § 432E-6(a)(2), *see* App. at 47a, affords Hawai'i's commissioner the option of obtaining a second opinion either from an IRO or a medical expert. Thus, the Maryland and Hawai'i schemes are alike in their differences from the primary purposes of the Illinois statute, and the passive scheme of the Illinois statute simply cannot be compared to Maryland's active regulatory plan any more than it can be compared with Hawai'i. Respondent's assertion that the Maryland law "much more closely resembles the Illinois statute," Opposition Brief at 19, plainly misstates the facts. Maryland and Hawai'i have active regulatory schemes alike in the material respects that differentiate them from the Illinois statute, and thus *Rush Prudential* does not provide the appropriate rule.

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[13] Respondent's contention that, "Under Hawaii law, the first level of external review by the Insurance Commissioner involves an evidentiary hearing before a three-member panel . . . " misstates the plain meaning of the statute and thus does not explain the Hawaii court's erroneous conclusions. Opposition Brief at 19.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted to resolve the conflict between the Maryland and Hawai'i state court decisions interpreting *Rush Prudential* and ERISA preemption, and to correct the Hawai'i court's erroneous consequential decision involving federal law.

Respectfully submitted,

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